



# Togo FY2016

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  
CBM – Christoffel Blinden Mission  
CDC – United States Centers for Disease Control and Prevention  
CDD – Community Drug Distributor  
CDTI – Community Directed Treatment with Ivermectin  
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 Incorporated  
LF – Lymphatic Filariasis  
M&E – Monitoring and Evaluation  
MDA – Mass Drug Administration  
MOE- Ministry of Education  
MOH – Ministry of Health  
NTD – Neglected Tropical Diseases  
OCP – Togo’s Onchocerciasis Control Program  
PCT – Preventive chemotherapy  
PHU – Peripheral Health Unit  
PZQ – Praziquantel  
SAC – School-Age Children  
SAE – Severe Adverse Event  
SCM – Supply Chain Management  
SIZ – Special Intervention Zones  
STH – Soil-Transmitted Helminths  
TAS – Transmission Assessment Survey  
TF – trachomatous inflammation – follicular  
TT – trachomatous trichiasis  
TIPAC – Tool for Integrated Planning and Costing  
UNICEF – United Nations Children’s Fund  
USAID – United States Agency for International Development  
USG – United States government  
WASH – Water, Sanitation and Hygiene  
WCBA – Women of child-bearing age  
WHO – World Health Organization

## COUNTRY OVERVIEW

### *Government and health structure of Togo*

Togo is a small West African country with an area of 56,600 km<sup>2</sup>, located between Benin (to the east), Ghana (to the west), Burkina Faso (to the north) and the Atlantic Ocean (to the south). Its population was 6 191 155 inhabitants in 2010, according to the national census, with a growth rate of 2.84% per year and 51.4% women and 48.6% men<sup>1</sup>.

There are two main climatic zones in Togo: an equatorial climate in the southern half of the country, with two dry seasons and two rainy seasons, and a humid tropical climate in the north characterized by a single rainy season and a single dry season.

The country 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 681 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.

### *Other NTD partners in country*

Fiscal year (FY) 2016 is the seventh year of integrated NTD control in Togo with United States Agency for International Development (USAID) funding through Health & Development International (HDI) and the fifth year through assistance from Family Health International (FHI360). 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), Bill & Melinda Gates Foundation, Emory University, Mectizan Donation Program, MOH Togo, NTD Support Center (Atlanta), PATH, Sightsavers, The Task Force for Global Health, and United Nations International Children's Emergency Fund (UNICEF).

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 IMA World Health, Croix Rouge, Handicap International, the United States Centers for Disease Control and Prevention (CDC) and Plan-Togo.

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<sup>1</sup> Report of the 4<sup>th</sup> general population census of Togo, 2010.

**Table 1: NTD partners working in country, donor support and summarized activities  
(donors active in Togo from May 2015 through September 2016)**

<b>Partner</b>	<b>Location (Regions/States)</b>	<b>Activities</b>	<b>Is USAID providing direct financial support to this partner? (Do not include FOG recipients)</b>	<b>Other donors supporting these partners/ activities?</b>
<i>Sightsavers</i>	<i>15 districts with onchocerciasis prevalence &gt;5%</i>	<i>Supports a second round of ivermectin distribution in 11 districts</i>	<i>No</i>	<i>None</i>
<i>APOC</i>	<i>Districts endemic for onchocerciasis</i>	<i>Provides continuing support for epidemiological and entomological surveillance for onchocerciasis (APOC ends Dec. 31, 2015)</i>	<i>No</i>	<i>Sightsavers, PATH</i>
<i>Bill &amp; Melinda Gates Foundation</i>	<i>Nationwide</i>	<i>Provides support for identification of individuals with trichiasis or hydrocele; supports surgeries for individuals with trichiasis/hydrocele</i>	<i>No</i>	<i>Christoffel Blinden Mission (trichiasis)</i>
<i>Mectizan Donation Program</i>	<i>32 districts</i>	<i>Facilitates provision of ivermectin for MDA for onchocerciasis</i>	<i>No</i>	<i>None</i>
<i>PATH</i>	<i>Nationwide</i>	<i>Supports surveillance for onchocerciasis through donated supplies</i>	<i>No</i>	<i>APOC, Sightsavers</i>
<i>Sightsavers</i>	<i>32 districts</i>	<i>Supports epidemiological and entomological surveillance, cross-border meetings, program reviews and trainings for onchocerciasis</i>	<i>No</i>	<i>APOC, PATH</i>
<i>UNICEF</i>	<i>Nationwide</i>	<i>Provides and distributes albendazole and Vitamin A for preschool children</i>	<i>No</i>	<i>None</i>

## **National NTD Program Overview**

### *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 schistosomiasis prevalence from 1 to 9.9%. In FY 2013, support for integrated MDA continued, with the addition of praziquantel treatment for high risk adults in areas of moderate prevalence (10-49.9%), and LF surveillance continued, but funding for LF morbidity management ceased.

Other activities supported by USAID include LF transmission assessment surveys (TAS) in FY 2012 and FY 2015 to confirm elimination of LF; a coverage validation survey in 2012 (FY 2013); 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); and in FY 2015 a nationwide integrated disease-specific assessment (DSA) for schistosomiasis, onchocerciasis, LF and STH. USAID has also supported trainings for accountants and training on the Tool for Integrated Planning and Costing (TIPAC), as well as travel to international meetings to present data on Togo's successes. The USAID-funded integrated MDA platform has also been used to leverage funding from other partners for trichiasis and hydrocele surgery.

#### *National NTD Program Overview*

Togo is currently operating off a five-year strategic plan for NTD control and elimination 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 2). All drug distribution activities are implemented through door-to-door distribution in the community, and distribution is integrated across the three diseases targeted with MDA: onchocerciasis, schistosomiasis, and STH.

*Lymphatic filariasis:* Lymphatic filariasis transmission was effectively interrupted in 2009, with the last MDA for LF occurring in 2009. The goal now is to obtain WHO verification of elimination in Togo. Togo's Program for the Elimination of Lymphatic Filariasis will begin preparing its dossier to submit to the WHO for validation of LF elimination. The necessary data will be available by the end of FY 2015, but Togo would like to collect entomologic data to complement the epidemiological data that indicate that LF has been eliminated from Togo and will continue looking for funding outside USAID for this work. Passive surveillance will end at the end of FY 2015 (see appendices 14 and 15 for information on Togo's LF surveillance methods) but Togo will continue to seek funds for surveillance in selected high-risk populations that pose a potential risk of reintroduction of LF into Togo. Togo's MOH also aims to provide care for lymphedema patients and surgery for hydrocele patients. Outside funding has been secured to identify cases of hydrocele during the MDA and to provide surgery, when appropriate, to as many of those individuals as possible. The WHO Global Programme to Eliminate Lymphatic Filariasis guidelines on LF elimination provide guidance for the LF elimination strategy, as well as for the validation of LF elimination in Togo.

*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% Mf. In October 2014, Togo's Onchocerciasis Control Programme (OCP) drafted and approved its Five Year Plan for Onchocerciasis Elimination (2015-2019). The objective is to reduce prevalence to below 1%

Mf in 100% of eligible villages through MDA. MDA will be closely scrutinized in these areas through intensified supervision to ensure all people eligible for treatment are identified and treated in areas with prevalence  $\geq 5\%$  Mf; these areas are already targeted for treatment twice per year. The program will also continue with information, education and communication (IEC) activities and behavior change communication (BCC). In 2016, HDI will support onchocerciasis surveillance activities previously supported by APOC. The MOH is planning, with support from partners, to conduct surveillance at sentinel sites in 20 districts as part of its onchocerciasis elimination plan<sup>2</sup>. These surveys will employ skin snip, Ov16 rapid test, and PCR (the latter funded through USAID OR funds) to help establish operational thresholds for use of Ov16 RDT. Entomological evaluations will be conducted in 5 districts. In addition, the MOH will implement surveys in all seven districts in Maritime region in the south to determine 1) whether MDA can be stopped in the four districts that have been receiving MDA and where there were no cases of onchocerciasis identified through surveillance conducted in 2012, and 2) to re-confirm that there is no onchocerciasis transmission in the three districts which were determined to be non-endemic during baseline mapping over 20 years ago. USAID currently supports MDA for onchocerciasis (as part of Togo's nationwide integrated MDA) in 32 of the 40 districts in Togo. Togo's Five Year Plan for Onchocerciasis Elimination is based on APOC's onchocerciasis elimination strategy and this plan will be revised to align with the new WHO recommendations on onchocerciasis elimination expected later in 2015.

*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 region 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. Treatment for adult women began in FY 2014, due to their daily household activities that put them at risk through frequent contact with water. A DSA conducted in FY2015 included schistosomiasis; results are pending but the data will be used to evaluate the treatment strategies for schistosomiasis. USAID currently supports MDA for schistosomiasis in 35 of Togo's 40 districts. The schistosomiasis control strategy is based on the prevalence-based treatment thresholds and populations outlined in WHO guidelines for Preventive Chemotherapy in Human Helminthiasis<sup>3</sup>. Target populations and treatment frequency in 2016 will be updated based on the results of the 2015 integrated DSA conducted in February-March 2015.

*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. Activities will include IEC and BCC and promotion of WASH. As with

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<sup>2</sup> Conceptual and Operational Framework of Onchocerciasis Elimination with Ivermectin Treatment, African Programme for Onchocerciasis Control/WHO, 2010.

<sup>3</sup> Preventive Chemotherapy in Human Helminthiasis, WHO, 2006.

schistosomiasis, an integrated DSA conducted in FY2015 included STH and results are pending but the data will be used to evaluate the treatment strategies for STH starting in 2016. Even so, starting in FY2016, all children will receive treatment with ALB at least once per year in accordance with Togo's new strategic plan for NTD control. USAID currently supports MDA for STH in 28 of Togo's 40 districts. The STH control strategy is based on WHO guidelines for Preventive Chemotherapy in Human Helminthiasis<sup>3</sup>.

**Trachoma:** Trachoma has never been targeted with MDA in Togo. Mapping of the northern, dry half of the country in 2009 revealed that the prevalence of active disease (trachomatous inflammation – follicular, TF) was <1%, although there was a suggestion of a higher prevalence in three districts. Follow-up cluster surveys those three districts in January 2011 indicated that the prevalence of TF was <1%, but the prevalence of TT in those districts was 0.33% across the three districts (range 0.1%-0.7%). Outside funding has been secured to identify cases of trichiasis during the June-July 2015 MDA and to provide surgery, when appropriate, to as many affected individuals as possible. The results of the 2015 June-July MDA will provide data on the prevalence of trichiasis that will allow the MOH to determine whether additional funding will be needed to provide surgery for all of the cases of trichiasis identified. Additionally, existing data on trachoma in Togo will be reviewed and appropriate follow-up mapping will be conducted, in preparation for Togo to demonstrate elimination of trachoma. The goal of the program is to maintain the prevalence of active trachoma below 1% and prevent those with trichiasis from progressing to blindness through surgery. The strategy is to promote appropriate WASH practices for prevention and to identify and treat persons with trichiasis.

**Table 2: Snapshot of the expected status of the NTD program in Togo as of September 30, 2015**

		Columns C+D+E=B for each disease*			Columns F+G+H=C for each disease*				
		MAPPING GAP DETERMINATION			MDA GAP DETERMINATION		MDA ACHIEVEMENT	DSA NEEDS	
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 receiving MDA as of 09/30/15		No. of districts expected to be in need of MDA at any level: MDA not yet started, or has prematurely stopped as of 09/30/15	Expected No. of districts where criteria for stopping district-level MDA have been met as of 09/30/15	No. of districts requiring DSA as of 09/30/15
					USAID-funded	Others			
Lymphatic filariasis	40	8 <sup>a</sup>	32	0	0	0	0	8	0 <sup>a</sup>
Onchocerciasis		32	8	0	32	15 <sup>b</sup>	0	0 <sup>c</sup>	35 <sup>c</sup>
Schistosomiasis		40	0	0	35 <sup>d</sup>	0	5 <sup>g</sup>	0 <sup>c</sup>	0
Soil-transmitted helminths		40	0	0	28 <sup>e</sup>	40 <sup>f</sup>	12 <sup>g</sup>	0 <sup>c</sup>	0
Trachoma		0 <sup>h</sup>	40	0	0	0	0	0	0

<sup>a</sup> 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. All 8 endemic districts have successfully passed three TAS.

<sup>b</sup> The second round of MDA in the fifteen districts with a high prevalence of onchocerciasis is supported by the MOH of Togo and Sightsavers. These 15 districts also receive USAID funded distribution in the first round.

<sup>c</sup> For onchocerciasis, more data are needed before the decision to stop MDA can be made. FY2016 includes plans to launch epidemiological and entomological surveys in the seven districts of Maritime region to guide program decisions about stopping MDA in Maritime. DSA will include three districts that were determined to be non-endemic for onchocerciasis and which have



not received MDA with ivermectin, but which have not been evaluated in over twenty years. Ongoing epidemiological evaluations at sentinel sites are needed in all districts of the four other regions outside Lomé. For schistosomiasis and STH, data from the FY 2015 DSA are still being analyzed.

<sup>d</sup>All 35 districts outside of Lomé have ongoing MDAs for schistosomiasis. Schistosomiasis is present in the five districts in Lomé region but at a prevalence below the WHO treatment threshold. 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 2016, all but six of the 35 endemic districts (all but Avé, Bas Mono, Golfe, Lacs, Vo, and Danyi, in the south of the country) will have MDA for schistosomiasis. In these six districts, all endemic areas received treatment in 2015 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 6 (the Togo Disease Workbook for Work Plan FY 2016).

<sup>e</sup>The five districts in Lomé region and seven districts outside of Lomé all have a prevalence of STH below 20% and so, although endemic for STH, are not targeted for MDA among school-age children. Treatment with ALB of all SAC outside of Lomé is planned in FY 2016, and plans to treat children in Lomé in FY 2017 (in conjunction with PZQ treatment) will be discussed.

<sup>f</sup>Children under five years of age are treated with albendazole, through UNICEF, in all 40 districts.

<sup>g</sup>There are five districts for schistosomiasis and twelve districts for STH that are not currently treated. The five districts in Lomé region have a prevalence  $<10\%$  for schistosomiasis and a prevalence  $<20\%$  for STH; the Integrated NTD Program in Togo is contemplating starting treatment in Lomé in FY 2017. There are also seven districts outside of Lomé with a prevalence of STH  $<20\%$ . These seven districts are not currently targeted for treatment but will be in FY 2016, in keeping with Togo's new Five Year Strategic Plan for NTDs which aims to treat all SAC for STH at least once a year.

<sup>h</sup>The prevalence of active trachoma in Togo is  $<1\%$ , nevertheless, the country remains on the WHO list of endemic countries due to a prevalence of trichiasis  $>0.1\%$ . Trichiasis surgeries are needed to reduce the prevalence of trichiasis to below 0.1%.

## PLANNED ACTIVITIES

### Project assistance

Project assistance planned for FY 2016<sup>4</sup> is as follows:

- HDI will support two rounds of integrated MDA in Togo. The second round of treatment for calendar year 2015 occurs in October 2015, and is called the “second” round because it is the second (and smaller) treatment round for the calendar year, although it actually occurs at the beginning of the US government (USG) fiscal year. The *first* round of treatment refers to April of calendar year 2016, and is a nationwide MDA, although this “first” round occurs second in the USG fiscal year.
- Togo will implement integrated nationwide MDA for onchocerciasis, schistosomiasis and STH in April 2016 (the “first” round of treatment in calendar year 2016, but the second round of treatment in FY 2016; see also Table 4). Targets are:
  - Onchocerciasis – 3,064,494 people/32 districts;
  - Schistosomiasis<sup>5</sup> – 2,433,363 people/29 districts;
  - STH<sup>5</sup> – 2,330,732 school-age children/35 districts;
  - 100% geographic coverage of at-risk areas.
- A second round of integrated MDA for calendar year 2015 will be conducted for onchocerciasis (15 districts, funded by USAID and Sightsavers) and STH (four districts, funded by USAID) in high

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<sup>4</sup> FY 2016 = U.S. government fiscal year 2016, which runs from October 1, 2015 to September 30, 2016.

<sup>5</sup> These figures will be updated according to the results of the integrated disease assessment conducted in early 2015, once the results become available; results are expected by the end of July 2015.

prevalence areas in October 2015. All of these districts are also targeted during the larger April 2016 MDA. Targets are:

- Onchocerciasis – 1,593,054 people/15 districts;
  - STH<sup>5</sup> – 211,726 SAC/4 districts.
- HDI will assist Togo in preparing a dossier for submission to the WHO for the verification of elimination of LF.
- LF morbidity management: Hydrocele surgery will be provided for affected individuals identified during the 2015 June MDA using funding from the Bill & Melinda Gates Foundation. Lymphedema morbidity management will continue if external funding can be secured.
- HDI will provide technical and logistical assistance and will help with coordination of partners and activities aimed at advancing the OCP's transition from control to elimination of onchocerciasis in Togo. This will include support of quarterly meetings of an Onchocerciasis Elimination Committee, which will be comprised of onchocerciasis experts and stakeholders both within and outside Togo.
- Epidemiological assessments for onchocerciasis will be conducted in 60 villages (17 districts) (USAID, through HDI, will at least partially finance all assessments, with the entire assessment being covered by USAID in 24 villages). HDI will now be providing support for those activities previously supported by APOC. Sightsavers and the Christoffel Blinden Mission (CBM) also provide support for some of these epidemiological assessments. These partners will purchase certain supplies for the epidemiological surveys; specific components of the work that are supported by Sightsavers can be found on the budget tabs "epi 13v" and "epi 12v", and the contributions of CBM can be found on budget tab "epi 11v".
- HDI will also support entomological surveillance previously supported by APOC.
- Surveys to support stopping MDA will be conducted in the 7 districts of Maritime region in the south, as the next step towards onchocerciasis elimination.
- HDI will assist with the review and revision of Togo's Five Year Plan for Onchocerciasis Elimination, to align the strategy with the new WHO guidelines on onchocerciasis control and elimination, expected later in 2015.
- The NTD Program will continue to collaborate with WASH by disseminating IEC materials and BCC messages during the MDA for NTDs.

## **Strategic Planning (Onchocerciasis meeting, Secretariat, Work plan meeting tabs)**

- Togo has a five-year strategic plan for the integrated control of NTDs (2012-2016) in place. HDI will work with the MOH to develop 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 may be affected by progress with onchocerciasis elimination), and plans for the long-term management of STH and schistosomiasis. This meeting will include 19 people and will last for three days.
- Togo's OCP has committed to elimination of onchocerciasis, and has developed a five-year strategic plan for onchocerciasis elimination. HDI will help coordinate and will participate in collaborative efforts with multiple partners (Togo MOH, USAID, FHI360, The Task Force for Global Health, Centers for Disease Control and Prevention, Sightsavers, and other collaborators/scientific researchers) to conduct epidemiological and entomological surveys for making decisions on stopping MDA and for

post-MDA surveillance. HDI will provide support to quarterly meetings of an Onchocerciasis Elimination Committee, which will be comprised of onchocerciasis experts within and outside Togo, including representatives from USAID, FHI360, and other partners (up to 40 persons for 3 days). These meetings will provide a format for Togo's OCP to plan and review elimination activities as well as to coordinate partners' contributions and solicit external expert input into strategic planning. International partners will have to provide their own funds for attending these meetings.

- HDI will also support two M&E cross-border meetings. These meetings will include NTD partners within Togo, representatives from neighboring countries, and external experts, to develop effective and sustainable M&E strategies for Togo in anticipation of a transition away from external funding in the future. These meetings will include up to 20 people for 3 days and will discuss cross-border issues (e.g. meetings, synchronized treatments).
- As in past years, HDI will support one work planning meeting to assemble 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.

### **NTD Secretariat (Microplanning, Secretariat tabs)**

HDI supports several NTD secretariat activities:

- One annual program review of the Integrated NTD Program/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 MDA; 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 health 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. Sightsavers, etc.). This meeting will also include a program review, including analysis of the results, successes and challenges associated with MDAs, coverage surveys, DSAs, and/or evaluation of progress against annual and longer-term strategic goals.
- Four meetings (one per quarter) of the NTD secretariat for planning and coordinating NTD activities.

### **Advocacy (No associated budget)**

The MOH is requesting technical assistance in developing an advocacy plan. HDI will continue to advocate for additional NTD funding within the MOH during stakeholder meetings and other meetings with MOH and governmental leadership.

### **Social Mobilization (FOG #2, Printing tabs)**

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 communicate social mobilization messages in the village's local language during the FY 2016 MDA, and are supervised by the nurses. Radio announcements are in French and regionally appropriate languages.

IEC materials (flip charts) used during the MDA will be updated in 2016, and 6,000 copies will be produced to create the full complement of copies needed for the 2016 MDA.

## Capacity Building/Training (FOG #1-4 MDA)

In FY 2016, 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 its own role is primarily supportive. Training in FY 2016 will pertain to implementation of the MDA and onchocerciasis epidemiological and entomological assessments (Table 3).

More CDDs were implementing the MDA than have been identified in previous budgets. In order to ensure that all CDDs are receiving appropriate training, materials, and supervision, we have increased the number of CDDs to better reflect the number of CDDs implementing the MDA.

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 Togo MOH has specifically requested training for key MOH personnel on the collection, interpretation, and use of data to improve program performance (evidence-based program management). This is in line with the focus on capacity building in the Togo MOH management in FY 2016, and short-term technical assistance will be requested to assist with this.

**Table 3: Training targets**

Training Groups	Training Topics	Number to be Trained			Number Training Days	Location of training(s)	Name other funding partner
		New	Refresher	Total trainees			
MOH/MOE at Central Level	Supervision skills; how to train trainers, SCM skills	0	18	18	2	Lomé	None
Trainers	Supervision skills; how to train trainers, SCM skills	15	105	120	3	Regional headquarters	None
Supervisors / PHU nurses	MDA procedures; training of CDDs, SCM skills	0	632	632	3	District HQ	COGES*

CDDs	IEC and drug distribution procedures for NTDs, and IEC for WASH	902	9,750	10,652	2	PHUs	COGES*
Field workers for entomological surveillance for onchocerciasis	All aspects of field implementation: field navigation, informed consent, laboratory techniques and safe handling of samples, data recording	12	12	24	2	Kara	None
Field workers for epidemiological surveillance for onchocerciasis	All aspects of field implementation: field navigation, informed consent, laboratory techniques and safe handling of samples, data recording	15	25	40	2	Kara	Sightsavers**
Training on logistics/supply chain management (district level chiefs)	Capacity building on logistics and supply chain management	42	0	42	5	(to be determined)	None
NTD program coordinators from selected NTD programs and key staff (central level)	Capacity building on collecting, interpreting and applying data to improve program performance	17	0	17	3	Kpalimé	None
Accountants (central and regional level)	Refresher training to reinforce management of Fixed Obligation Grants (FOG)	0	8	8	2	Lomé	None

\*COGES=Comité du gestion des formation sanitaires (Committee for the management of peripheral health units).

\*\*Sightsavers will provide funding for some of the per diems for field workers and some of the supplies for epidemiological surveillance in 25 villages (see attached budget, Appendix 7). HDI will be supporting the Ov16-related work in these villages, both through per diems for Ov16 field technicians and provision of supplies.

### Mapping (Additional trachoma assessment)

Existing data on trachoma in Togo will be reviewed and appropriate follow-up assessment will be conducted, in preparation for Togo to demonstrate elimination of trachoma.

## **MDA (Supervisor training, HDI MDA, FOG #1-4, Drug delivery, Data collection, Printing)**

In 2011, Togo reached 100% geographic coverage of areas requiring MDA for all diseases targeted and has maintained 100% geographic coverage since then (see coverage map at end of work plan).

Two rounds of treatment are conducted each year. The first distribution of the calendar year is considered the first round (although it occurs second in the USG fiscal year) and occurs in April or May. This round of treatment is nationwide and includes treatment for all endemic NTDs targeted with MDA; in Togo, these are onchocerciasis, schistosomiasis, and STH. The second round of treatment typically occurs six months after the first round of treatment, usually in October or November, and targets only those districts with high baseline prevalence of onchocerciasis (15 districts) or STH (4 districts, one of which is also targeted for treatment for onchocerciasis).

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. The geographic areas and populations targeted for all three diseases may be amended (either expanded or reduced) depending on the results of planned and completed (but not yet fully analyzed) DSAs.

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, see also Appendix 9). 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.

The Onchocerciasis Control Program has drafted and approved its Five-Year Plan for Onchocerciasis Elimination. Historically, only villages with population  $\leq 2000$  have been treated through MDA because individuals in those villages were determined to be at high risk of blindness. Given the shift to elimination, this practice is under review and the treatment plan, including target populations and frequency of treatments, will be amended according to the results of planned epidemiological surveys. Table 4 currently reflects the onchocerciasis target population based on the historical approach of only treating villages with population  $\leq 2000$ .

Treatment for STH is being expanded to all children living in districts with STH, including those districts where the prevalence of STH is less than 20%, in line with Togo's updated NTD strategic plan. Women of childbearing age (WCBA) will also be treated in moderate and high prevalence areas using the USAID-funded distribution platform if funding can be found to procure the albendazole for WCBA.

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 4: USAID-supported districts and estimated target populations for MDA in FY16  
(according to information available in May 2015)**

*Column definitions correspond to those found in the workbooks*

<b>NTD</b>	<b>Age groups targeted (per disease workbook instructions)</b>	<b>Number of rounds of distribution annually</b>	<b>Distribution platform(s)</b>	<b>Number of districts to be treated in FY16†</b>	<b>Total # of eligible people targeted in FY16†</b>
Lymphatic filariasis	--	0	--	0	0
Onchocerciasis	All persons age 5 years and older	1 round	Community MDA, door-to-door	17 endemic districts	1,671,943
Onchocerciasis	All persons age 5 years and older	2 rounds	Community MDA, door-to-door	11 previously SIZ <sup>s</sup> districts and 4 districts with prevalence >5%	1,392,551
Schistosomiasis	School-age children in low prevalence areas (prevalence 1-9%)	1 round every two years	Community MDA, door-to-door	149 PHUs from 15 districts	67,664
Schistosomiasis	School-age children and high-risk adults (HRA) in moderate prevalence areas (prevalence 10-49%)	1 round every two years	Community MDA, door-to-door	256 PHUs from 16 districts	772,053
Schistosomiasis	All persons age 5 years and older in high prevalence areas (prevalence ≥50%)	1 round annually	Community MDA, door-to-door	162 PHUs from 27 districts	1,593,646
Soil-transmitted helminths	School-age children in low (1-19%) and moderate (20-	1 round	Community MDA, door-to-door	31**	1,982,357

	49%) prevalence areas*				
Soil-transmitted helminths	School-age children in high prevalence areas (≥50% prevalence)*	2 rounds	Community MDA, door-to-door	4	248,375
Trachoma	--	0	--	0	0

\*Women of childbearing age (WCBA) will also be treated in moderate and high prevalence areas using the USAID-funded distribution platform if funding can be found to procure the albendazole for WCBA.

\*\*Treatment for STH is being expanded to all children living in districts with STH, including those districts where the prevalence of STH is less than 20%, in line with Togo's updated NTD strategic plan. The only exception is treatment in Lomé, which will not begin in 2016 but may begin in 2017.

†The numbers of districts, PHUs, or people targeted for treatment will be updated once the results of the disease-specific assessment conducted in early 2015 are available (results expected by the end of July).

§SIZ=Special Intervention Zones, those areas targeted by the former Onchocerciasis Control Program in West Africa to focus ivermectin treatments in areas of higher transmission.

## MDA Challenges

Overall, epidemiological and program coverage have been excellent in Togo, and above the minimum target levels (Table 5). Nevertheless, there are a few challenges that have been identified that have adversely affected coverage.

The main challenge relating to MDA relates to preventive chemotherapy (PCT) for onchocerciasis, as mentioned in the FY 2015 Work Plan. During field supervision during the April 2014 MDA, it was determined that there are specific groups (miners, sawyers, nomadic groups, sand/gravel workers, fishermen) who reside in the area only at certain times of the year and may not be present during the MDA. These untreated individuals 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. Togo is addressing 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.

Other difficulties identified through the 2012 coverage survey include: 1) people reporting that they did not receive treatment because there were "not enough drugs", 2) coverage for girls was lower than for boys in one district, and 3) only 52% of individuals reported having been shown a flip chart. Spot checks by supervisors during the 2014 MDA suggest that these issues may be improving, but the results of the FY 2015 coverage survey will provide better data on whether these problems have been fully addressed.



**Table 5: Explanation of low USAID-supported program and epidemiological coverage**

*Epidemiological coverage targets are defined below. Programmatic coverage targets are >=80% eligible population*

NTD	Epi coverage targets	Number of districts with complete coverage information*	Number of districts that did not meet coverage targets*	Reason(s) for poor district performance	Proposed remediation actions (bulleted list, with detailed narrative below table)
Lymphatic filariasis	>=65% epi coverage	N/A	Epi: N/A		
		N/A	Program: N/A		
Onchocerciasis	>=65% epi coverage	32	Epi: 0		
		32	Program: 0		
Schistosomiasis	>=75% epi coverage of SAC	29	Epi: 0		
		29	Program: 1**	Poor coverage (60.5%) among high-risk adults (coverage of 98.6% for SAC, coverage of 77.8% overall)	<ul style="list-style-type: none"> <li>During training, reinforce that high risk adults must be treated</li> <li>Increase supervision in this district in future MDAs</li> </ul>
Soil-transmitted helminths	>=75% epi coverage of SAC	28	Epi: 0		
		28	Program: 0		
Trachoma	>=80% epi coverage	N/A	Epi: N/A		
		N/A	Program: N/A		

\*Data are from May 2014 MDA.

\*\* Dankpen district

One district, Dankpen, had poor overall programmatic coverage (77.8%) due to poor coverage among high-risk adults (60.5%). Coverage among SAC was good (98.5%). The poor coverage among high-risk adults appears to be an aberration rather than a trend. In future MDAs, during training of drug distributors for this district, there will be particular emphasis on the need to treat high-risk adults. There will also be intensified supervision in this district.

## Drug and Commodity Supply Management and Procurement (Drug delivery tab)

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 2015 and will do so again in FY 2016. For FY 2015, the form was submitted after WHO's August 2014 deadline, the request was then not forwarded by the WHO regional office to the WHO central office, and follow-up

inquiries from Togo about the order were not posed until April 2015. Ultimately, the albendazole order was filled, but it arrived in Togo more than a month later than the planned MDA. In FY 2016, HDI will ensure that the completed joint request form is submitted to WHO well in advance of the August deadline and, through regular follow-up emails, will confirm that the order is proceeding as needed through the WHO system. The request for praziquantel for FY 2016 has already been submitted.

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. HDI reviews the drug distribution guide developed by the MOH.

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. HDI conducts the physical inventory of drugs with MOH personnel.

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.

The Togo MOH has requested TA for training on supply chain management for personnel at the district level (see Table 6).

#### *Adverse events*

Identification, management, and reporting of adverse events are taught at the trainings. The CDD refers the patient immediately to the PHU dispensary closest to his locality. All adverse events are managed in accordance with Togo's national system of pharmacovigilance.

Serious cases are hospitalized. All cases are to be reported to the district supervisor and regional supervisor and notification of the case is to be sent by email or fax. The regional supervisor reports the serious adverse event (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.

Reporting of adverse events appears to be working well. While reports of mild adverse events are received, there were no SAEs reported from the FY 2014 MDAs.

## **Supervision (HDI MDA, Data collection tabs)**

As in past years, 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 2016. Primary responsibility for supervision lies with the districts. The PHU nurse is responsible for assuring effective rollout 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. Technical assistance will be requested to provide training on supply chain management at the district level.

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 higher 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. Any errors in the distribution will be specifically addressed in the training for the next year's MDA.

## **Short-Term Technical Assistance (No associated budget)**

The MOH requests technical assistance for capacity building for program coordinators and other key personnel at the central level on evidence-based program management. They would also like assistance with building capacity on developing and implementing an advocacy plan to help mobilize resources for the program. They also request refresher FOG training for accountants at the central and regional level, and supply chain managers at the district level (the level at which supply chain issues are most likely to arise). The TA is requested from Deloitte (for FOG training and advocacy planning) and from MSH for supply chain management. The partner has yet to be determined for providing TA on evidence-based

program management. TA for surveys to decide about stopping MDA for onchocerciasis in Maritime region will be requested from CDC or Task Force for Global Health.

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

<b>Task-TA needed (Relevant Activity category)</b>	<b>Why needed</b>	<b>Technical skill required; (source of TA (CDC, RTI/HQ, etc))</b>	<b>Number of Days required and anticipated quarter</b>
Capacity building on evidence-based program management - training of program managers and other key personnel from selected NTD programs	MOH has requested training on evidence-based program management	Expertise in management training/evidence-based program management (to be determined)	One week, Q2
Capacity building on developing and implementing an advocacy plan to mobilize resources for the NTD program - training of program managers and other key personnel from selected NTD programs	The MOH wishes to improve their advocacy skills and their ability to mobilize resources	Expertise on advocacy and resource mobilization (Deloitte)	Two days, Q1
Capacity building on FOG - training for accountants	MOH has requested refresher training on working with FOGs	Expertise on Fixed Obligation Grants (Deloitte)	Two days, Q1
Training on supply chain management at the district level (Supply chain management, capacity building)	Supply chain issues that have arisen have occurred within districts*	Expertise on supply chain management (MSH)	1 week, Q1
Review and revision of Togo's Onchocerciasis Program's Five Year Plan for Onchocerciasis Elimination, in conjunction with Togo's new Onchocerciasis Elimination Committee	New WHO guidelines on onchocerciasis elimination will be available in June/July 2015; Togo's strategy will need to be updated to align with these new guidelines.	Expertise on onchocerciasis control and elimination and familiarity with the new WHO onchocerciasis guidelines (CDC, FHI360/USAID)	1 week, Q1
Consultation on design of survey to stop MDA for onchocerciasis in Maritime region	Epidemiological and entomological surveys to stop MDA must be properly designed and implemented according to the local onchocerciasis situation and such that WHO requirements for such surveys are met.	Expertise on onchocerciasis study design for assessing whether MDA with IVM can be stopped (CDC or Task Force for Global Health)	Remote consultation (Q1) and 1 week, Q2

\* Specific problems noted include: 1) significant amounts of damaged medications, 2) issues with proper accounting of inventory, 3) sub-optimal management and storage of medications made available to the program.

## M&E (Onchocerciasis tab)

The major components of M&E for FY 2016 are:

- Conduct data quality assessments (DQA) using the DQA tool developed by RTI International's ENVISION project to assure the availability of reliable and meaningful data to inform programmatic decisions;
- Conduct epidemiological assessments for onchocerciasis in 17 districts (60 villages) as part of the sentinel site surveillance that is part of Togo's Five Year Plan for Onchocerciasis Elimination;
- Conduct epidemiological and entomological surveys for onchocerciasis in the seven districts of Maritime region in the south, where results of epidemiological surveillance have been excellent, to evaluate the possibility of stopping MDA with ivermectin in this region as the next step in moving to onchocerciasis elimination;
- Conduct entomological assessments for onchocerciasis previously funded by APOC as part of the ongoing surveillance for onchocerciasis and as preparation for the move to elimination.
- Review and revise onchocerciasis surveillance activities as warranted, through the new onchocerciasis elimination committee meetings, to ensure that there is a comprehensive surveillance system in place in areas where MDA will be stopped.

### *Disease-specific assessments in FY 2016*

Epidemiological surveillance for onchocerciasis will be conducted in 20 districts (60 villages) to provide the preliminary information necessary to determine whether MDA can be stopped. Additionally, conduct assessments in the seven districts in Maritime region to evaluate the possibility of stopping MDA with ivermectin in this region. Further review of existing data will be conducted to determine the exact locations and schedule of these assessments. The onchocerciasis elimination committee will assist in this process.

**Table 7: Planned Disease-specific Assessments for FY16 by Disease**

Disease	No. of endemic districts	No. of districts planned for DSA	Type of assessment	Diagnostic method (Indicator: Mf, ICT, hematuria, etc)
Onchocerciasis	32	17	Epidemiological surveillance	Skin snips, Ov16 rapid test
		7	Epidemiological assessment, to determine whether MDA can be stopped	Skin snips, Ov16 ELISA
		5	Entomological assessment	Fly capture and dissection and Poolscreen PCR

### *Post-treatment surveillance in 2016*

No USAID-funded post-treatment surveillance is planned for Togo in FY2016. The final TAS for LF was completed in January 2015 and there is no evidence of LF transmission in Togo. Togo plans to submit a dossier to WHO for validation of LF elimination in Togo; in FY 2016 HDI will provide assistance to Togo in preparing the dossier.

### *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. 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-HQ technical lead.

In FY 2016, as in previous years, the population data from the current MDA are compared with population data from the previous year. If there are dramatic differences in the enumerated populations the differences are 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 updated yearly after the MDA population enumeration.

Results from the 2015 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 2016 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.

In 2016, Togo will utilize the DQA Tool developed by RTI's Envision project to assess data quality of Togo's Integrated NTD Program. HDI will support the MOH in this work.

#### *M&E challenges*

Past challenges relating to the calculation of the population at risk, the population requiring PCT, and the target population for MDA have been resolved. Togo now consistently uses the following definitions in its disease workbooks.

- Population at risk: the total population in areas where the NTD is considered endemic, regardless of whether the persons are eligible to receive PCT.
  - For onchocerciasis, treatment is currently implemented in villages with fewer than 2000 people in those districts that were found to be endemic for onchocerciasis according to baseline mapping. The population at risk is all persons living in those villages that are targeted for treatment with ivermectin.
  - For schistosomiasis the implementation unit is the PHU and the population at risk is all persons living in PHUs with prevalence of schistosomiasis >0%.
  - For STH, the implementation unit is the district, and the population at risk is all persons living in a district with prevalence of STH >0%.

- Population requiring PCT: the proportion of the at-risk population that should be targeted with treatment according to WHO guidelines
  - For onchocerciasis, the population requiring PCT is all persons aged 5 years or older in the population at risk, which is the same as all persons aged 5 years or older living in villages with <2000 people in districts found to be endemic for onchocerciasis at the time of baseline mapping.
  - For schistosomiasis, the population requiring PCT is those persons living in a PHU with a prevalence of schistosomiasis >0% who would ever be targeted for treatment with praziquantel according to WHO guidelines. The terminology “who would ever be targeted for treatment” is used because people who are targeted every other year should always be included in the population requiring preventive chemotherapy even though they may not be targeted in the current year.
  - For STH, the population requiring PCT is those persons who should be treated with albendazole according to WHO guidelines plus all children living in districts with prevalence of ALB>0%. Pre-school age children and women of child bearing age are therefore included in the population requiring PCT with ALB although Togo has not always been able to acquire ALB for women of child bearing age. UNICEF treats the pre-school age children with ALB.
- Population targeted for treatment: the proportion of the population requiring PCT that should receive treatment that year or that treatment round according to WHO guidelines.

The denominators for these calculations will be based on the population enumerated during the MDA, and the populations for each district will be updated once per year, after the nationwide MDA in April-May.

#### *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.

## Planned FOGs to local organizations and/or governments

Table 8 lists the four fixed obligation grants (FOGs) to the Togo MOH that are planned for FY 2016.

**Table 8: Planned FOG recipients**

FOG recipient	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>

## 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.

While there is available funding from the Bill & Melinda Gates Foundation to identify patients who require surgery for trichiasis and hydrocele and to provide surgery for some of those patients, the assessment of the burden of disease will not be completed until later in FY 2015. It is therefore not yet certain, but likely that there will be need for additional funding to provide all the necessary surgeries.

For LF, entomological funding is similarly needed to provide key data to support the case that LF has been eliminated. Togo would be very interested in participating in LF entomological research funded through USAID or other partners.

There have been a number of recent reports of yaws in Togo, and the MOH would also like funding to investigate the extent of yaws in Togo.

The Togo MOH is both open to and interested in participating in opportunities for operational research into any of its endemic NTDs, and the country is well situated for such work due to its talented researchers, small size, and institutions with strong technical capabilities.



**Table 9: Remaining gaps to be addressed**

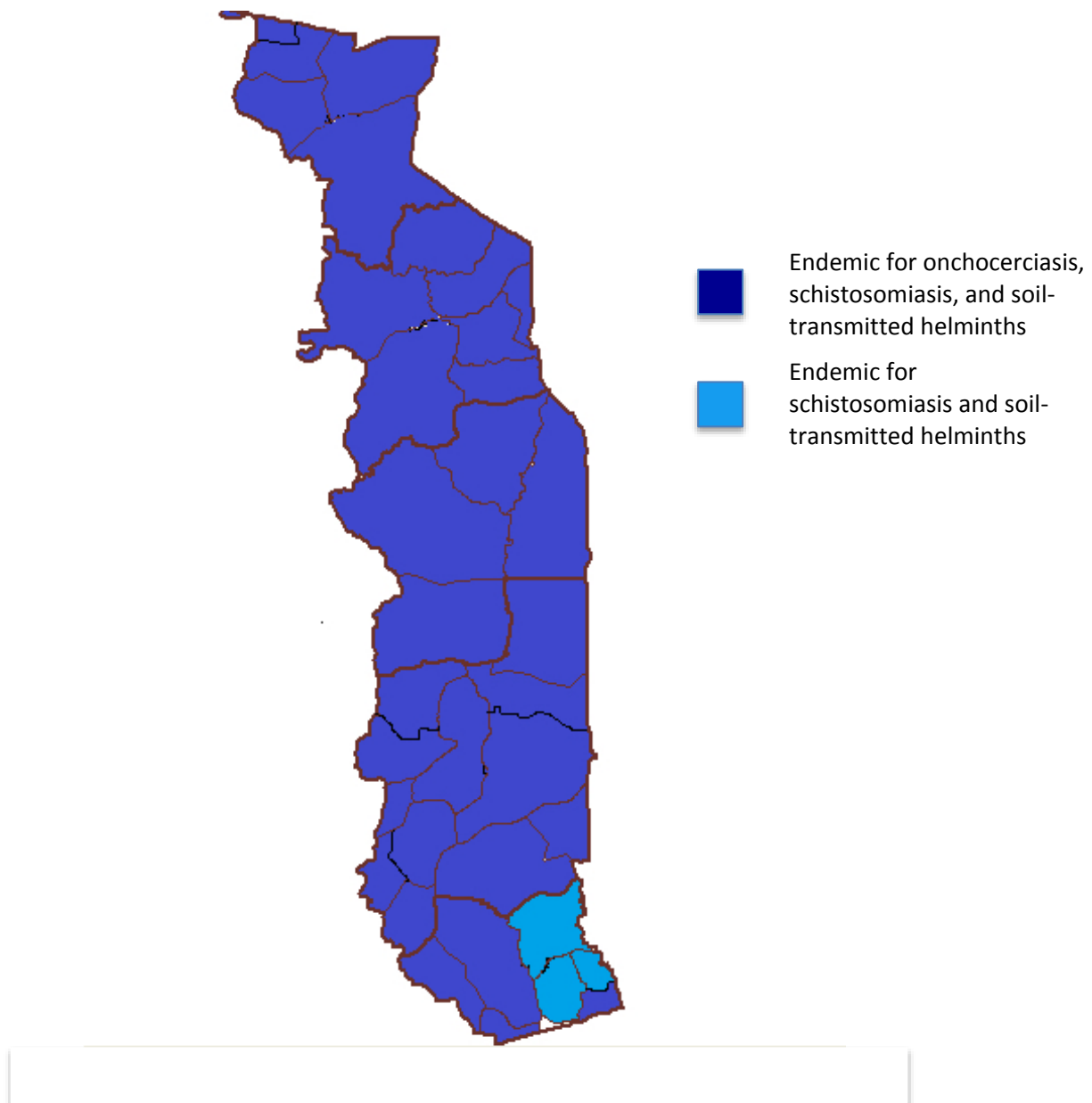
<b>Identified gap or activity</b>	<b>Would external support be needed –funding or technical?</b>	<b>Estimated time needed to address activity</b>	<b>Estimated cost to carry out activity</b>
LF morbidity management	Funding	Ongoing	\$40,000/year
Trichiasis surgery	Funding	Two years	\$75,000*/2 years
Hydrocele surgery	Funding	Two years	\$75,000*/2 years
LF entomological survey	Funding mosquito collection†	One survey	\$40,000/ survey
Evaluation of yaws in Togo	Funding	Annual survey	\$12,000/year

\*Some funding for these activities was obtained from the Bill & Melinda Gates Foundation. It has yet to be determined what the remaining funding need will be at the end of the BMGF grant, which expires in April 2016.

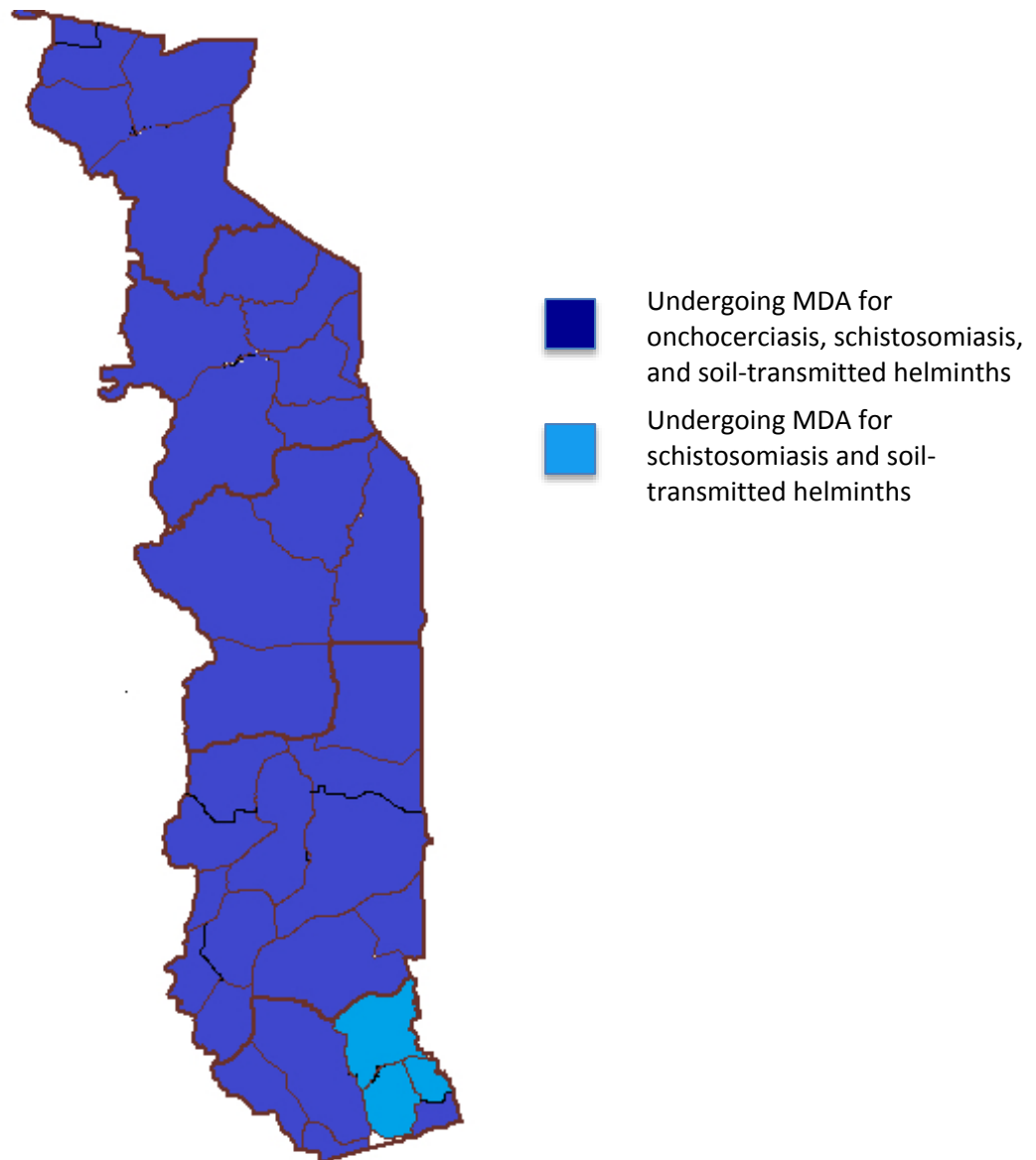
†Togo lacks funding for the mosquito collection for LF entomological surveillance. If the collection piece is funded, other partners are willing to support the laboratory dissection and investigation (see also Appendix 9).

## Maps

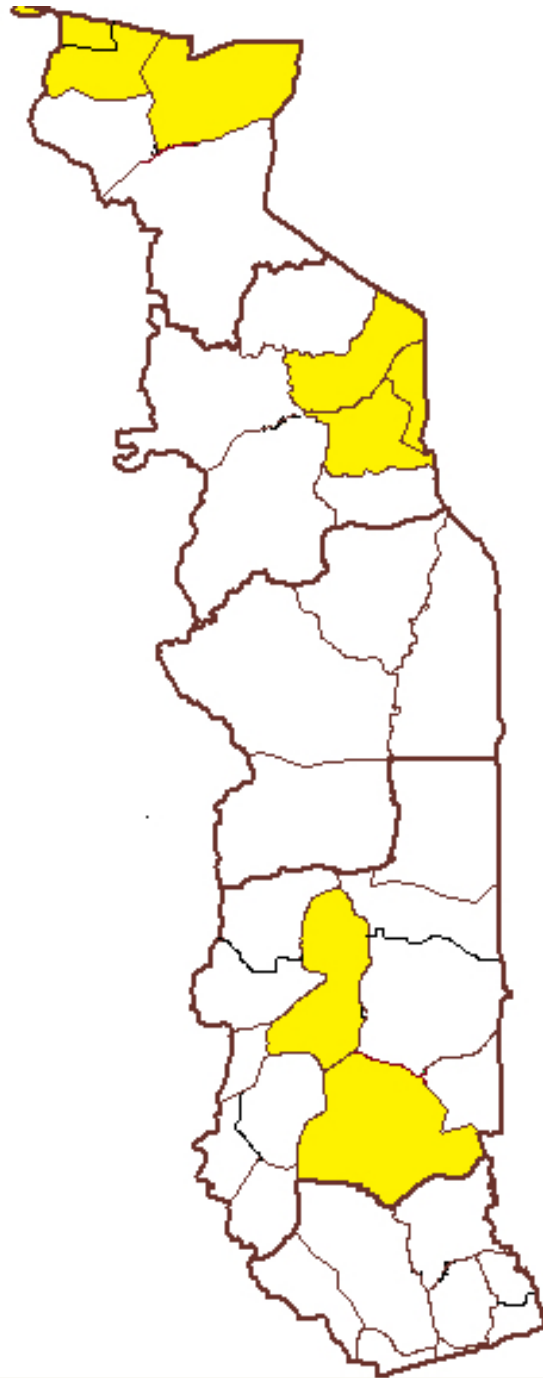
Below are maps of Togo showing disease presence by district (Map 1), MDA by district (Map 2), LF districts that have stopped MDA and passed three TAS (Map 3), and onchocerciasis districts that need DSA.



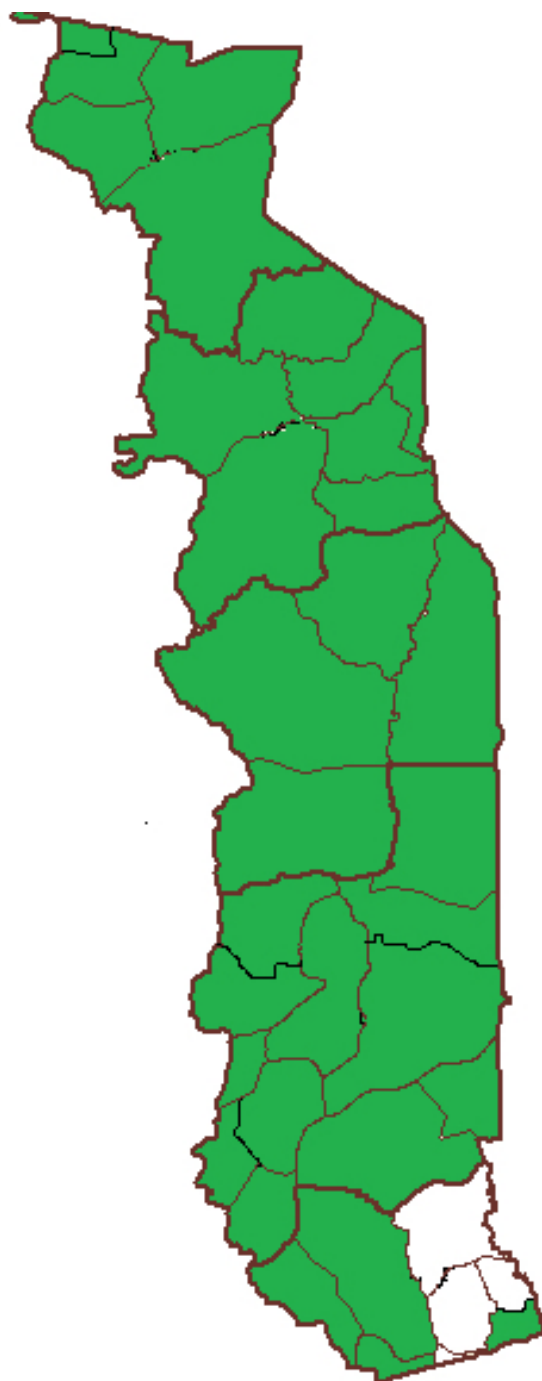
Map 1. Disease presence in Togo by district: Although LF was endemic in eight districts in Togo, it is not shown on this map, as there is no LF transmission in Togo.



Map 2. MDA in Togo by district: This map shows all areas receiving MDA in Togo.



Map 3. The eight districts that have stopped MDA for LF and have passed three TAS for LF: These eight districts are the only districts in Togo that were ever endemic for LF.



Map 4. Districts needing DSA for onchocerciasis (all 32 endemic districts): Togo has been conducting epidemiological surveillance for many years. In FY 2016 Togo will launch its first survey to stop MDA. All previously endemic LF districts have passed three TAS, and no DSA is needed for trachoma as active trachoma is not endemic in Togo and there has never been MDA for trachoma in Togo.

## **APPENDICES**

- 1. Country staffing/partner org chart**
- 2. Work plan timeline**
- 3. Work plan deliverables**
- 4. Table of USAID-supported provinces/states and districts**
- 5. Program Workbook**
- 6. Disease Workbook**
- 7. Country budget**
- 8. Travel Plans**
- 9. Treatment schedule by medication**
- 10. Article - on baseline mapping of schistosomiasis, STH, and trachoma in Togo**
- 11. Baseline mapping report with additional details on trachoma mapping (2009)**
- 12. Table from mapping report showing trachoma data from baseline mapping (2009)**
- 13. Trachoma cluster survey report (2011)**
- 14. Article – A Laboratory-Based Surveillance System for *Wuchereria bancrofti* in Togo: A Practical Model for Resource-Poor Settings**
- 15. Article – Ongoing Surveillance for Lymphatic Filariasis in Togo: Assessment of Alternatives and Nationwide Reassessment of Transmission Status**