Togo
FY2017

Control of Neglected Tropical Diseases

Annual Work Plan
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Acronyms and Abbreviations

AOP	Annual Operational Plan
APOC	African Programme for Onchocerciasis Control
BCC	Behavior Change Communication
CAMEG	Centrale d'Achats des Medicaments Essentials Generiques et des Consommables Medicaux
CBM	Christoffel Blinden Mission
CDC	Centers for Disease Control and Prevention
CDD	Community Drug Distributor
CDTI	Community directed treatment with ivermectin
COGES	Committee for the management of peripheral health units
DHIS	Demographic Health and Information System
DQA	Data Quality Assessment
DSA	Disease Specific Assessment
FHI360	Family Health International
FPSU	Filarial Programmes Support Unit
FY	Fiscal Year
HDI	Health & Development International
IEC	Information, Education, and Communication
IU	Implementation unit
JRSM	WHO Joint Request for Selected Medicines
LF	Lymphatic filariasis
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and evaluation
MDA	Mass Drug Administration
MF	Microfilariae
MMDP	Morbidity Management and Disability Prevention
MOE	Ministry of Education
MOH	Ministry of Health
NTD	Neglected Tropical Diseases
OEC	Onchocerciasis Elimination Committee
Ov16 RDT	Ov16 rapid diagnostic test for onchocerciasis
PHU	Peripheral Health Unit
PNLC	National Blindness Prevention Program
PNLO	National Onchocerciasis Control Program
RPRG	Regional Program Review Group
SAC	School-age children
SAE	Severe Adverse Events
SCM	Supply Chain Management
STH	Soil-transmitted Helminths
TA	Technical Assistance
TAS	Transmission Assessment Survey
TIPAC	Tool for Integracted Planning and Costing
TF	Trachomatous inflammation – follicular
TT	Trachomatous trichiasis
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
USG	United States government
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

Country Overview

Government and health structure of Togo

Togo is a West African country with an area of 56,600 km^2, 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. The population is estimated to be 7,049,503 in 2016, with 51.4% women and 48.6% men[1].

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 health regions containing a total of 40 districts, of which 35 are outside the capital region, Lomé-Commune. 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 (MDA) 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.

NB: Four new administrative districts were recently created, but district health positions have not yet been assigned, so implementation of health activities still fall under the health departments of their old, parent districts. Once the district-level health personnel are in place, however, this will result in an increase of the total number of health districts to 44. The budgets have been increased accordingly.

Other NTD partners in country

Fiscal year (FY) 2017 is the eighth year of integrated NTD control in Togo with United States Agency for International Development (USAID) funding through Health & Development International (HDI) and the sixth year through assistance from Family Health International (FHI360). Led by the Togo Ministry of Health and Social Protection (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): Bill & Melinda Gates Foundation, Emory University, Liverpool School of Tropical Medicine, Mectizan Donation Program, MOH Togo, NTD Support Center (Atlanta), PATH, Sightsavers, The Task Force for Global Health, United Nations International Children's Emergency Fund (UNICEF), and the World Health Organization (WHO).

The 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, and Plan-International (previously Plan-Togo). The United States Centers for Disease Control and Prevention (CDC) is currently planning programmatically pertinent onchocerciasis research in Togo in 2016 and 2017.

[1] Report of the 4th general population census of Togo, 2010.

Table 1: NTD partners working in country, donor support and summarized activities (donors active in Togo from June 2016 through September 2017)

Partner	Location (Regions/States)	Activities	Is USAID providing direct financial support to this partner? (Do not include FOG recipients)	List other donors supporting these partners/ activities
Bill & Melinda Gates Foundation	*Nationwide*	*Provides support for identification of individuals with trichiasis or hydrocele; supports surgeries for individuals with trichiasis/hydrocele*	*No*	*Sightsavers (trichiasis)*
WHO	*Nationwide*	*Provides technical and financial support for implementation of multiple NTD activities*	*No*	*Sightsavers*
Mectizan Donation Program	*32 districts*	*Provides ivermectin for MDA for onchocerciasis*	*No*	*WHO (facilitates customs clearance)*
PATH	*Nationwide*	*Supports surveillance for onchocerciasis through donated supplies and technical assistance regarding Ov16 ELISA*	*No*	*Sightsavers*
Sightsavers	*32 districts*	*Supports epidemiological and entomological surveillance, cross-border meetings, program reviews and trainings for onchocerciasis*	*No*	*None*
The Task Force for Global Health	*9 districts*	*Supporting surveillance by providing financing and technical assistance for Ov16 ELISA (onchocerciasis) and Wb123 ELISA (lymphatic filariasis)*	*No*	*PATH*
Liverpool School of Tropical Medicine/Filarial Programmes Support Unit	*8 districts*	*Supporting entomological surveys to further substantiate the elimination of lymphatic filariasis as a public health problem in Togo*	*No*	*WHO*
UNICEF	*Nationwide*	*Provides and distributes albendazole and Vitamin A for preschool children*	*No*	*None*

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 lymphatic filariasis (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-International), 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 (providing 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%. During FY 2013, support for integrated MDA continued, with the addition of praziquantel treatment for high risk adults in areas of moderate schistosomiasis 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. The STH and schistosomiasis results were used to revise the drug distribution plan for the two diseases, starting with the December MDA in 2015. The onchocerciasis component of the DSA utilized the Ov16 rapid test, providing information on the seroprevalence of antibodies to Ov16 in school-age children nationwide; these data were reviewed and incorporated into the recommendations of the MOH's newly established Onchocerciasis Elimination Committee (OEC) in Togo, which met in July 2016. The OEC is funded by USAID.

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 operational research and 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 2016-2020. 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. The implementation unit (IU) for onchocerciasis is the village, the IU for schistosomiasis is the PHU, and the IU for STH is the district.

Lymphatic filariasis: LF 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. In March 2016, Togo submitted its dossier to WHO for validation of LF elimination. The dossier was reviewed at the WHO's AFRO Regional Program Review Group (RPRG) in April 2016 and Togo is awaiting the report of the recommendations of the RPRG. Togo's LF Programme has also secured funding from the Liverpool School of Tropical Medicine's (LSTM) Filarial Programmes Support Unit (FPSU) to conduct entomologic studies to complement the epidemiological data indicating that LF has been eliminated from Togo. Togo continues to seek funding for surveillance for LF 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. With funding from the Bill & Melinda Gates Foundation, cases of suspected hydrocele were identified during the MDA in June 2015. Confirmation of suspected cases is

ongoing and surgeries are being provided to those individuals with confirmed hydrocele. The WHO Global Programme to Eliminate Lymphatic Filariasis guidelines inform the LF elimination strategy and guide the validation of LF elimination in Togo.

Onchocerciasis: The onchocerciasis program has a long history, beginning with larviciding in 1975, the addition of ivermectin treatment in selected communities in 1988, expansion to widespread community-directed treatment with ivermectin (CDTI) in 1997, and finally it served as the platform onto which integrated MDA for other NTDs was added, starting in 2010. Reported and measured coverage for ivermectin has been very high, and there are currently only fifteen communities known to have a prevalence of onchocerciasis >5% by skin snip. In October 2014, Togo's Onchocerciasis Control Programme (PNLO) drafted and approved its Five Year Plan for Onchocerciasis Elimination (2015-2019). The objective is to reduce prevalence to below 1% microfilariae (Mf) in 100% of eligible villages through MDA. MDA will be closely scrutinized in areas with prevalence >5% through intensified supervision to ensure all people eligible for treatment are identified and treated, including any groups who are seasonally present during transmission season but away when MDAs normally occur; 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, USAID supported onchocerciasis surveillance activities previously supported by the African Programme for Onchocerciasis Control (APOC). The MOH, with support from partners, conducted surveillance at sentinel sites in 20 districts as part of its onchocerciasis elimination plan[2]. These surveys employed skin snip and Ov16 RDT (rapid diagnostic test) to help establish baseline data on Ov16 seroprevalence.

In early 2016, the MOH established an OEC. Having held a preparatory meeting in April with partner support (WHO, Sightsavers, USAID, etc.), the committee held its first full meeting at the end of July 2016, which included international onchocerciasis experts. The report of OEC's July meeting is not yet available, but the Committee reviewed all of the PNLO's data and issued recommendations for next steps based on best estimates of transmission in different areas of the country. USAID currently supports MDA for onchocerciasis (as part of Togo's nationwide integrated MDA) in 32 of the 40 districts in Togo, and a second round of treatment in 15 districts. Togo's OEC will revise its Five Year Plan for Onchocerciasis Elimination in FY17, based on the new WHO recommendations on onchocerciasis elimination that were released in early 2016.

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 a prevalence below the WHO MDA treatment threshold. Treatment for adult women in areas of moderate prevalence (10%-49%) began in FY 2014 because their daily household activities place them at high risk due to frequent contact with water. A DSA was conducted in early 2015, after four to five years of MDA for schistosomiasis, and the results demonstrated that the prevalence of schistosomiasis was significantly reduced nationwide, from 23% to 5%, and the intensity of infection is low in infected individuals. The goal now is to reduce or maintain the prevalence of *S. haematobium* and

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

S. mansoni in school age children (SAC) below 10% in all areas. The strategy is to continue MDA according to disease prevalence in the PHU, and the target populations and frequency of treatment have been updated based on the results of the FY 2015 DSA and according to WHO guidelines for Preventive Chemotherapy in Human Helminthiasis[3]. In a small minority of PHU, the frequency of treatment for schistosomiasis will be increased to two times per year, according to WHO guidelines for treatment post-assessment. The program will continue with IEC and BCC activities and promotion of water, sanitation, and hygiene (WASH) principles. USAID currently supports MDA for schistosomiasis in 35 of Togo's 40 districts.

Soil transmitted helminths: As with schistosomiasis, the baseline 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 2015 DSA showed an overall reduction in the prevalence of STH among school children from 33% to 11.6% after 4 to 5 years of MDA, and those infected mostly have light infections. The goal now is to reduce or maintain the prevalence below 20% in all areas. Activities will include MDA with IEC and BCC and promotion of WASH. Togo's new strategic plan for NTD control calls for all children to receive treatment with albendazole at least once per year. USAID currently supports MDA for STH in 35 of Togo's 40 districts according to the MOH policy of treating all children in districts with STH prevalence ≥1%.

Trachoma: 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 difficulties with the implementation of this survey led to the suggestion that the prevalence might be near the MDA threshold in three districts. Follow-up cluster surveys in those three districts in January 2011 indicated that the prevalence of TF was <1%, but the prevalence of trachomatous trichiasis (TT) in those districts was 0.33% across the three districts (range 0.1%-0.7%). Based on the results of this mapping, trachoma has never been targeted with MDA in Togo. Outside funding was secured from the Bill & Melinda Gates Foundation to identify individuals with eye diseases during the June-July 2015 MDA. In the northern region of Togo, follow-up examination of several thousand individuals identified through the MDA revealed that only 0.7% of the individuals with eye diseases had trichiasis. Those individuals with confirmed trichiasis received surgery, but not all cases could be confirmed and treated due to funding limitations. The goal of Togo's Blindness Prevention Program (PNLC) is to maintain the prevalence of active trachoma below 1% and provide surgery to individuals with trichiasis to prevent their disease from progressing to blindness. The strategy is to promote appropriate WASH practices for prevention and to identify and treat persons with trichiasis.

[3] Preventive Chemotherapy in Human Helminthiasis, WHO, 2006.

Table 2: Snapshot of the expected status NTDs targeted with preventive chemotherapy in Togo as of September 30, 2016

		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 09/30/16		No. of districts expected to be in need of MDA at any level: MDA not yet started, or has prematurely stopped as of 09/30/16	Expected No. of districts where criteria for stopping district-level MDA have been met as of 09/30/16	No. of districts requiring DSA as of 09/30/16
					USAID-Funded	Others			
Lymphatic filariasis	40	*8[a]*	*32*	*0*	*0*	*0*	*0*	8	*0[a]*
Onchocerciasis		*32*	*8*	*0*	*32*	*15[b]*	*0*	*0[c]*	*35[c]*
Schistosomiasis		*40*	*0*	*0*	*35[d]*	*0*	*5[g]*	*0[c]*	*0*
Soil-transmitted helminths		*40*	*0*	*0*	*35[e]*	*40[f]*	*5[g]*	*0[c]*	*0*
Trachoma		*0[h]*	*40*	*0*	*0*	*0*	*0*	*0*	*0*

[a] 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 previously endemic districts. All 8 endemic districts have successfully passed three TAS.
[b] The second round of MDA in the fifteen districts with a high prevalence of onchocerciasis is supported in part by the MOH of Togo, and is now additionally supported by USAID. These 15 districts also receive USAID funded distribution in the first round.
[c] For onchocerciasis, more data are needed before the decision to stop MDA can be made. FY 2017 includes plans to launch epidemiological and entomological surveys according to the conclusions of the Onchocerciasis Elimination Committee, which met the last week of July 2016. For schistosomiasis and STH, treatment will continue to prevent rebound of infection.
[d] 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 PHU level; high (≥50%) prevalence PHUs are treated every year while PHUs with moderate (10-49%) or low (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 2017, all but four of the 35 endemic districts (all but Sotouboua, Tchambe, Dankpen, and Tandjoaré in the north of the country) will have MDA for schistosomiasis. In these four districts, all endemic areas received treatment in 2016 and they do not have any PHUs where treatment is warranted based on the WHO algorithm for treatment after an impact assessment; 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).
[e] The five districts in Lomé region were not treated for STH in 2016. Although all but four districts outside of Lomé had a prevalence of STH <20% in the 2015 DSA (only Anié, Haho, Ogou and Vo districts had STH prevalence ≥20%), SAC in all 35 districts outside of Lomé were treated with albendazole in May 2016 in accordance with Togo's Five Year Plan for NTD Control which states that all SAC will be treated for STH at least once per year.
[f] Children under five years of age are treated with albendazole, through UNICEF, in all 40 districts.
[g] There are five districts for schistosomiasis and STH that are not currently treated. The five districts in Lomé region have a prevalence <10% for schistosomiasis and a prevalence <20% for STH.
[h] 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

NTD program Capacity Strengthening

Togo has good capacity for implementing, managing, and evaluating their NTD Program. Through technical assistance from Deloitte, the NTD Program's managerial team has conducted a situation analysis, identified resource gaps, and undertook the development of an advocacy plan for identifying and mobilizing resources, for example from the private sector within Togo. Implementation capabilities remain strong in Togo, as evidenced by good programmatic coverage and reduction of the prevalence and burden of disease demonstrated by the 2015 impact assessment. Capacity to evaluate the program will be expanded, for example through training on and implementation of the Data Quality Assessment (DQA) tool in FY 2017 (see training, Short-term technical assistance (STTA), and Monitoring and Evaluation (M&E) sections).

Areas of demonstrated Program capacity in the past year include: the ability to identify, investigate, and manage severe adverse events, use of the TIPAC, increased advocacy skills, and, through an operational research activity piggy-backed on the USAID work, the ability to perform Ov16 ELISA and analyze and troubleshoot these assays.

Additional capacity strengthening activities planned for FY 2017 include: training/mentoring of the NTD Program accountant by the HDI accountant, planning monitoring and evaluation for elimination of onchocerciasis (with support from HDI and the OEC), training on the Data Quality Assessment tool and the WHO NTD database, training additional laboratory personnel on conducting Ov16 ELISAs to increase capacity for onchocerciasis evaluations, the development of additional skills related to the TIPAC, additional advocacy planning, and hopefully, through USAID leverage of outside funding, training on entomologic techniques for onchocerciasis.

Program management has been good, but high-level managerial staff has been increasingly burdened by an expanding scope of work and number of tasks expected of them; this situation needs to be rectified. The country has undertaken to develop a new organogram for the MOH, establishing a national coordination and National Coordinator for the Integrated Program of the Control of Neglected Tropical Diseases that may help improve the situation.

The establishment of an elimination committee, with sub-committees for the elimination of specific diseases (LF, onchocerciasis, and human African trypanosomiasis), demonstrates commitment to elimination as a goal for these diseases.

Project assistance

Project assistance planned for FY 2017[4] is summarized as follows, with detailed description provided in the respective sub-sections:

- Togo will implement integrated nationwide MDA for onchocerciasis, schistosomiasis and STH in April 2017 (this round is considered the "first" round of treatment in calendar year 2017, but is the second round of treatment that occurs in FY 2017; see also Table 5). Current targets are:
    - Onchocerciasis – 2,939,167 people/32 districts;

[4] FY 2017 = U.S. government fiscal year 2017, which runs from October 1, 2016 to September 30, 2017.

    - Schistosomiasis – 2,096,940 people/31 districts;
    - STH – 2,139,186 SAC/34 districts;
    - 100% geographic coverage of at-risk areas.
- A second round of integrated MDA for calendar year 2016 will be conducted for onchocerciasis (15 districts, funded by USAID and Sightsavers), schistosomiasis (21 districts, funded by USAID), and STH (six districts, funded by USAID) in high prevalence areas in November 2016. All of these districts are also targeted during the larger April 2017 MDA. Targets are:
    - Onchocerciasis – 1,452,741 people/15 districts;
    - Schistosomiasis – 850,447 people/21 districts;
    - STH – 257,205 SAC/6 districts.
- LF morbidity management will continue if external funding can be secured.
- During the MDA, CDDs will demonstrate how to chlorinate drinking water using chlorine tablets and a month's supply of tablets will be provided to each household, if external funding can be secured to support the addition of this activity to the MDA.
- HDI will provide technical and logistical assistance in support of the elimination of onchocerciasis in Togo. This will include support for three meetings of Togo's OEC, one of which will include technical experts from outside Togo.
- Although the official report and recommendations of the first meeting of Togo's OEC are not yet available, the following activities are planned based on the results gleaned from attendance at that meeting and discussion with the PNLO:
    - Epidemiological assessments for onchocerciasis will be conducted in all five regions outside Lomé in 2015:
        - Routine epidemiological surveillance activities will be conducted in 97 villages in 4 regions: Savanes, Kara, Centrale and Plateaux. Sightsavers and the Christoffel Blinden Mission (CBM) will also provide support for some of these epidemiological assessments.
        - HDI will support stop-MDA surveys for onchocerciasis in the Maritime region as the next step towards onchocerciasis elimination.
    - If funding is available, HDI will also support entomological surveillance for onchocerciasis at 16 sites across all 5 regions, using the new WHO guidance that recommends using only PCR technique.
    - HDI will support community outreach to village chiefs and residents in areas with persistent onchocerciasis and/or poor ivermectin coverage to improve community participation in MDA campaigns as part of the path towards onchocerciasis elimination.
    - Togo's NTD and Onchocerciasis Programs will convene cross-border meetings with Benin and Ghana to address areas along those borders that pose a problem for onchocerciasis elimination.
    - HDI will support a rapid assessment approach in the three districts of Cinkassé, Tone, and Kpendjal in the north, utilizing a rapid assessment protocol implemented in Ethiopia, as a quick and inexpensive means to determine whether a full scale stop-MDA survey is warranted.
- The MOH has revised its Five Year Plan for the control of NTDs (2016-2020), which includes the objectives and strategies for the elimination of onchocerciasis as well as the plans for long-term management of STH and schistosomiasis. HDI will review and comment on this plan, and will support dissemination of the plan through an official launch and regional meetings.
- HDI will provide assistance to the PNLO to update its Five Year Plan to reflect the 2016 WHO guidelines on the elimination of onchocerciasis.

- HDI will provide technical assistance to the NTD Program in the analysis of the 2015 coverage validation survey.
- The MOH will be trained on, and will implement use of, the Integrated NTD Database and the DQA tool.
- The NTD Program will continue to collaborate with WASH by disseminating IEC materials and BCC messages during the MDA for NTDs.
- HDI will support the development of an Annual Operational Plan (AOP) for 2017 and 2018 for the Integrated NTD Program in Togo. This AOP will detail all NTD activities planned by the integrated NTD Program in Togo, not just those supported by USAID.

Strategic Planning **(Budget tabs: Oncho meeting, Strategic Planning, Microplanning, Secretariat)**

Total cost for activities in this section: $82,349

- Togo has a five-year strategic plan for the integrated control of NTDs (2016-2020) in place that includes updated goals and strategies for onchocerciasis elimination, updated strategies for onchocerciasis surveillance, and plans for the long-term management of STH and schistosomiasis. HDI will review this plan and work with the MOH to update it as needed. (no associated budget)
- Togo also has a five-year strategic plan for onchocerciasis elimination, and this plan will be updated in FY 2017 to reflect the latest WHO guidelines for onchocerciasis elimination. HDI will help coordinate and will participate in collaborative efforts with multiple partners (Togo MOH, USAID, FHI 360, The Task Force for Global Health, CDC, Sightsavers, and other collaborators/scientific researchers) to conduct epidemiological and entomological surveys for making decisions on stopping MDA, to investigate problem areas, and to implement post-MDA surveillance. (no associated budget)
- HDI will support one annual program review of the Integrated NTD Program/microplanning meeting per year. The microplanning component of the meeting will 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 Directorate in charge of planning, 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 Control Program, the Ministry of Education (MOE), the Ministry of Social Action, and other partners (e.g. Sightsavers, etc.; 103 people for 5 days). The program review consists of 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. An HDI representative will attend these meetings to ensure that progress is being made and long-term strategic goals are being met, particularly with regard to USAID-funded activities. (Microplanning)
- HDI will provide support to three meetings of the OEC, which will be comprised of onchocerciasis experts within Togo and, for one meeting per year, experts from outside Togo, including representatives from USAID, FHI 360, and other partners (30 people for 3 days). At these meetings experts will review progress made on action points recommended at the most recent meeting, review the most recent onchocerciasis data from Togo, and outline specific next steps on the road to elimination. The committee will also serve to coordinate partners' contributions to elimination and solicit external expert input into strategic planning. HDI will support the travel of external experts for participation in these meetings. HDI staff will provide secretarial, technical and logistical

assistance to these meetings, including review, analysis and presentation of data, coordination of experts, and support for implementation of recommendations from the OEC. (Oncho meeting)

- As in past years, HDI will support one work planning meeting to assemble USAID, FHI 360, HDI and in-country partners to develop the annual work plan for integrated NTD control activities that are supported by funding from USAID (30 participants for 4 days). (Strategic Planning - Work Plan meeting)
- HDI will support two cross-border meetings (one with Benin, one with Ghana). These meetings will include NTD partners within Togo and representatives from neighboring countries to develop effective interventions for border areas and collaborative M&E strategies 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 address a range of cross-border issues (e.g. problem areas, synchronized treatments, approaches to M&E). (Strategic Planning – Cross-border meetings)
- The MOH is in the process of updating the TIPAC and conducting an in-depth analysis of the resulting data, with support from Deloitte. The outputs from the TIPAC are used for program planning. In FY 2017, HDI will support an annual meeting to update the TIPAC (25 people for 6 days), identify funding gaps, and elaborate and execute a plan for addressing those gaps. (STTA – no associated country budget)
- After the TIPAC has been updated and results analyzed, HDI will support meetings to update the 2017 and 2018 Annual Operational Plans of the Integrated NTD Control Program. These meetings will consist of representatives of all the NTD programs, the directorate in charge of planning at the MOH, and selected regional and districts personnel (19 people for 3 days). The Annual Operational Plan will inform the annual USAID Work Planning meeting and will allow a more streamlined approach to ensuring that NTD program support from multiple partners (including USAID) is efficient and coordinated. (Strategic Planning – Operational Plan Meetings)
- HDI will support four meetings (one per quarter) of the NTD secretariat which are held for planning and coordinating NTD program activities (18 people for 1 day). An HDI representative will attend these meetings. (Secretariat)

NTD Secretariat **(Equipment – MOH, Office expenses – Internet MTN Togo Dr. Sognikin)**

Total cost for activities in this section: $2,860

HDI supports the NTD Secretariat through the provision of reliable internet access and office supplies.

Advocacy for Building a Sustainable National NTD Program

In-country advocacy for NTDs in FY 2016 included a situation analysis conducted by the MOH with technical assistance from Deloitte. The workshop, led by Deloitte for the MOH, provided insight into the role of advocacy as one of the four pillars of program sustainability. Examination of the organizational maturity model helped the NTD team assess the strengths and limitations of the program in 14 organizational areas, including advocacy and partnership management. The workshop also helped define a financing strategy that identified the gaps in funding according to activities outlined in the master plan and based on the analysis of data in the TIPAC. This financing strategy will serve as a basis for advocacy to sustain funding. The MOH will identify opportunities for soliciting support from local public and private entities: the state, local collectives, Committee for the management of peripheral health units (COGES), the private sector, research centers, etc. Certain sectors, such as the Ministry of Education, have already provided significant support to the implementation of the NTD Program.

Specific advocacy efforts planned for FY 2017 include:

1) Formalizing the national integrated coordinating body for NTDs. Establishing a coordination for NTDs confers additional resources to the NTD entity as compared with having only a national Focal Point for NTDs.

2) Creating a national budget line item for NTDs. This process aims to develop political will to support the efforts of partners and community stakeholders.

3) Developing strategic social partnerships to engage the private sector in funding and support for NTD control.

The NTD Program is aware that state resources are scarce and it is becoming increasingly difficult to meet all needs. This led the NTD Program to commit to advocacy and the development of a funding strategy to anticipate possible changes in the portfolio of partners. However, there are several important obstacles:

- the slow response of local business partners whose assistance is solicited
- the limited capacity and experience of the advocacy team
- the limited number of partners willing to participate

Advocacy directed at the government and partners is needed to reinforce the technical and financial resources of the program. This will be addressed through additional STTA from Deloitte, to organize a stakeholder meeting and mobilize resources.

The funding strategy will include indicators for measuring progress in the mobilization of resources, and the MOH would like to develop, in FY 2017, an advocacy plan that includes measurable indicators of success in advocacy efforts. In FY 2017 HDI will support a meeting of partners to mobilize resources in support of NTD activities. (Strategic Planning – Stakeholders Meeting)

Social Mobilization to Enable NTD Program Activities **(FOGs – FOG 2 Social Mobilization, HDI MDA – MDA Kick-off, HDI MDA – Community Sensitization in 15 high-prevalence onchocerciasis villages)**

Total cost for activities in this section: $43,210

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 2017 MDA, and are supervised by the nurses. Radio announcements are in French and local languages. (FOGs – FOG 2 Social Mobilization)

The nationwide MDA is begun with a high profile celebration, generally featuring a high-level politician announcing the start of the MDA and taking the medications as part of a press conference that is televised widely. (HDI MDA – MDA Kick-off)

The primary IEC materials used during the MDA are laminated flip charts, with photos on one side and short, educational messages for the CDDs to read out loud on the back (see Annex 9. These flip charts were updated in 2016 to simplify the messages about proper health and hygiene practices; pictures of certain rare or eliminated diseases (Noma and Guinea worm) were removed. The 2012 coverage survey also found that, of respondents who reported having been shown a flip chart by their CDD, a higher proportion were able to list appropriate health and hygiene practices for preventing infection with the NTDs than were people who did not report having seen a flip chart.

In addition to the routine social mobilization activities, there will be intensive community sensitization and mobilization in villages with onchocerciasis prevalence ≥5%. This activity will consist of a preliminary meeting with the village chief and village elders, followed by a community meeting held in conjunction with the chief, to describe the current situation with onchocerciasis in Togo, discuss onchocerciasis elimination, and highlight the importance of community participation in the MDA, and the impact of that participation for both the immediate community and communities across Togo. (HDI MDA – Community Sensitization in 15 high-prevalence onchocerciasis villages)

Table 3 Social Mobilization/Communication Activities and Materials Checklist for NTD work planning

Category	Key Messages	Target Population	IEC Strategy (materials, medium, activity etc.)	Where/when will they be distributed	Frequency	Is there an indicator/mechanism to track this material/activity? If yes, what?	Other Comments
MDA Participation	*MDA will take place during XXX dates.*	*Community members*	*Radio broadcast*	*Nationwide (in French and local languages) before and during the April MDA*	*At least three times daily x 5-6 weeks*	*% of persons who report having heard about the MDA on the radio (rapid assessment during MDA supervision)*	
	MDA is taking place tomorrow/ today	*Community members*	*Town criers*	*In villages the day before and day of the MDA*	*Several times each day x 2 day*	*% of persons who report having heard about the MDA through town criers (rapid assessment during MDA supervision)*	
	MDA is beginning and will continue over the next XXX weeks	*Community members, press*	*Television*	*Local television on day of and day after launch of MDA*	*Several times each day x 2 days*		*Official MDA launch ceremony with high-ranking MOH officials is televised*
	Take the medications to prevent certain diseases (pictured on the flip charts)	*Community members*	*Flip charts*	*Shown to household members by the CDDs when they visit each household*	*Once during the drug distribution and education activity*		

Disease Prevention	*Engage in these practices (wash hands, wash face, sleep under LLIN, use latrine, take MDA medications*	*Community members*	*Flip charts*	*Shown to household members by the CDDs when they visit each household*	*Once during the drug distribution and education activity*		
Intensified community outreach in villages with oncho prevalence ≥5% by skin snip	*Information on onchocerciasis, onchocerciasis elimination, and the key role of MDA*	*Communities with high onchocerciasis prevalence*	*Community meetings held in conjunction with village chiefs, flip charts,*	*Held 1-2 weeks prior to the MDA in target villages*	*One meeting with village chief/elders, followed by one community meeting*	*Epidemiological coverage for onchocerciasis in these villages, onchocerciasis prevalence in f/u epidemiological surveys*	

Training (Supervisor Training; FOGs – FOG 2 – Nurse Training, CDD Training; Supervisor Training, HDI MDA – Nurse Training, CDD Training; OV16 and Schisto, Accountant Training, Supplemental budget - Ento Summary)

Total cost for activities in this section: $285,160 plus $5,369 supplemental

Trainings planned for FY 2017 are as follows:

MDA Implementation (rows 1-5 of Table 4)

Central, regional, district, and peripheral level personnel, including CDDs, will be trained on MDA implementation. These trainings are conducted every year, and for most participants this will be a refresher training, but because the MDA is a critical activity for this program, and because certain aspects of implementation change every year, including the distribution plan for many PHU, it is important to provide refresher training for all experienced participants, as well as training for new participants. (Supervisor Training; FOGs – FOG 2 – Nurse Training, CDD Training; HDI MDA – Nurse Training, CDD Training)

Onchocerciasis field activities (rows 6-10 of Table 4)

There is a need for new and refresher training for field activities related to onchocerciasis elimination. While there is already capacity to conduct both entomological and epidemiological assessments for onchocerciasis, there is a need to train:

- additional field workers on collection of samples for Ov16 testing (OV16 and Schisto)
- field workers on entomological field techniques (Supplemental budget - Ento Summary)
- villagers on human capture of black flies (Supplemental budget - Ento Summary)
- laboratory personnel on Pool Screen PCR for analysis of black flies (Supplemental budget - Ento Summary)
- laboratory personnel on Ov16 ELISA, to increase capacity for processing Ov16 ELISA for onchocerciasis surveillance and elimination

Supply Chain Management

Personnel from different levels (central, regional, district, PHU) will receive training on supply chain management (SCM), to improve adherence to recommended best practices for drug management and

timely return of medications and data after the MDA. This should also help address some of the issues with drug management identified during the May 2016 MDA (see Drug and Commodity Supply Management and Procurement). District level personnel have not previously received training specifically on SCM. (STTA)

Data Management/M&E
Central and regional level will be trained on the use of the Integrated NTD database and on the DQA tool, as part of capacity strengthening for improved and autonomous M&E. (STTA)

Accounting
If funding is available, HDI's accountant will hold a refresher training for district, regional, and central level accountants as well as the NTD Focal Point and LF Program Coordinator to update them on the best practices of accounting for USAID-funded NTD activities, including requirements for managing USG funds and how to manage payments in the field in an appropriate and auditable fashion. (Accountant Training).

Table 4: Training targets

Training groups	Training topics	Number to be trained			Number training days	Location of training	Other funding partner
		New	Refresher	Total			
MOH/MOE at Central Level	Supervision skills; how to train trainers, SCM skills	0	12	12	2	Lomé	None
Trainers	Supervision skills; how to train trainers, SCM skills	0	150	150	3	Regional head-quarters	None
Supervisors / PHU nurses	MDA procedures; training of CDDs, SCM skills	0	654	654	3	District HQ	None
CDDs	IEC and drug distribution procedures for NTDs, and IEC for WASH	300	10,652	10,952	2	PHUs	None
Town criers	Standardization of the message disseminated by the town criers	6,000	0	6,000	1	PHU	None
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	7	6	13	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
Male villagers	Capturing black flies for entomologic evaluation for onchocerciasis	88	0	88	1	On site in villages	None
NIH laboratory personnel, Lomé	Pool screen PCR for onchocerciasis	6	0	6	2	Lomé	None
Laboratory technicians	Training on Ov16 ELISA to increase laboratory capacity for onchocerciasis evaluations	5	0	5	5	*Lomé*	None

Training on logistics/ supply chain management (central, district, and PHU level)	Capacity building on logistics and supply chain management	42	0	42	5	To be determined	None
NTD program coordinators and M&E focal points (central and regional levels)	Training on use and application of WHO integrated NTD database.	25	0	25	3	Kpalimé	None
NTD program coordinators and M&E focal points	Training in the NTD Data Quality Assessment Tool	12	0	12	2	Lomé	None
Accountants (district-level)	Refresher training to reinforce management of funds in the field	0	50	50	2	*Lomé*	None
NTD program data managers (central level)	Training on ArcGIS and graphic presentation of data (emphasis on onchocerciasis)	6	0	6	5	*Lomé*	None

**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 (Supplemental budget – Trachoma)

Total cost for activities in this section: $296,461

Existing data on trachoma in Togo has been reviewed and, if funding is available, confirmation mapping will be conducted to provide the necessary evidence to demonstrate elimination of trachoma. (Supplemental budget – Trachoma)

MDA Coverage and Challenges (HDI MDA – Community Sensitization in 15 high-prevalence onchocerciasis villages)

Total cost for activities in this section: $3,241 (already included in Social Mobilization section above)

Coverage targets are best examined individually for each target disease, because although the distribution of all three drugs is integrated, the implementation unit is the district for STH, the PHU for schistosomiasis, and the village for onchocerciasis. Consequently, coverage estimates differ for these three diseases even when all three diseases are targeted in a given district.

Program coverage

For STH and schistosomiasis, program coverage is very high (>95% in all districts). Because the enumerated population for the current MDA is used as the denominator for calculating program coverage for STH and schistosomiasis, the coverage does not exceed 100%. For onchocerciasis, there is not a simple line-list of those villages that are targeted for onchocerciasis, so the target population is typically extrapolated from the enumeration of the previous MDA. This results in a less stable and accurate estimate of the denominator (the target population for onchocerciasis), and program coverage estimates reflect this variability in the estimate of the denominator. As can be seen in the Disease Workbooks for Togo, the programmatic coverage for onchocerciasis varies widely, and can be over

100%. There are 6 districts with program coverage <85%, but on average, nationwide program coverage was 98%, which indicates that some of the issues with program coverage may be related to differences between the distribution of the population in the denominator (estimated target populations) that of the population of the numerator (number of people treated). That is, people are being treated (overall coverage is satisfactory), but the denominator does not accurately reflect where those people reside.

Although some, if not most, of the poor program coverage for onchocerciasis may be attributable to inaccuracies in the denominator, some of these poor coverage rates are likely due to actual poor coverage. To determine where the problem lies, HDI will assist the NTD Program in generating a line list of all onchocerciasis villages targeted once or twice per year, and use those lists to recalculate coverage rates, which may correct some of the coverage numbers. However, the poor coverage rates may reflect actual coverage problems. A supervisory visit in April 2016 revealed a potential problem that may adversely affect ivermectin coverage, particularly in high-risk villages. Approximately 300 villages that have had persistent onchocerciasis are targeted for skin snip surveys every three years on a rotating basis. In these villages, treatment is withheld at the time of the MDA and the survey teams treat the entire population after the skin snip survey is completed. We have learned that sometimes instructions are sent to a village indicating that it has been selected for a skin snip survey, and that treatment with ivermectin should therefore be withheld at the time of the MDA, but then due to lack of funding or other issues, the skin snip survey is never conducted and the villagers are therefore never treated. This is particularly problematic as this non-treatment is happening in those very villages that have had persistent problems with, or are at higher risk for, onchocerciasis. This problem will be addressed through more rigorous supervision, record keeping and follow-up of villages that are scheduled for skin snip surveys. If for some reason the skin snip survey is not completed, then a mop-up drug distribution campaign will be instituted to ensure that those villages are treated with ivermectin.

Epidemiological coverage

Epidemiological coverage rates are more difficult to interpret. For STH, the expected epidemiological coverage is about 30%, because the target population for STH is SAC, and SAC make up approximately 30% of the total population. For onchocerciasis, the expected epidemiological coverage is approximately 84%, because the target population is all persons age 5 years and older, and these people comprise about 84% of the total population. These percentages are used for calculating the number of districts not meeting epidemiological coverage targets in Table 5. For schistosomiasis, in a given peripheral health unit, the target population might be all people age 5 and older, all SAC plus all adult women, or simply all SAC. For this reason, the expected epidemiological coverage for schistosomiasis is therefore very complicated to calculate and is not a particularly useful measure for schistosomiasis treatment in Togo.

The two districts that did not reach 30% epidemiological coverage for STH were very, very close: 28% in Zio district and 29% in Kloto district. Since 30% is an estimate of the proportion of the population that is SAC, these figures still reflect excellent epidemiological coverage for STH. For onchocerciasis, there are 19 districts with epidemiological coverage <84%, but again, the same issues with the calculation of the denominator exist as for the calculation of program coverage, and again, the overall epidemiological coverage nationwide is 82.5%, so quite close to the estimated 84% of the population that are SAC and adults. We will employ the same steps and interventions to assess and improve epidemiological coverage for onchocerciasis as for program coverage for onchocerciasis.

High-prevalence onchocerciasis villages

There are currently 15 villages known to have a prevalence of onchocerciasis ≥5%. Coverage of these villages appears to be good, but an in-depth analysis of population and coverage data for these villages will be undertaken at the central level. Most importantly, previous field work has indicated that the highest prevalence onchocerciasis villages have had issues with drug distribution related to very specific local factors: departure of a key leader who emphasized MDA treatment, absence of a local CDD and substitution of that CDD with one of a different ethnic background, or specific local issues impeding access to the target population. Prior to the next MDA, a team will visit each village and meet with the village chief and local CDD to discuss the situation. A follow-up community meeting will be held to sensitize the community to the importance of the MDA and to address local issues of coverage. (HDI MDA – Community Sensitization in 15 high-prevalence onchocerciasis villages)

Table 5: USAID supported coverage results for FY15 ** and targets for FY17

NTD	# Rounds of annual distribution	Treatment target (FY15) # DISTRICTS	# Districts not meeting epi coverage target in FY15*	# Districts not meeting program coverage target in FY15*	Treatment targets (FY15) # PERSONS	# persons treated (FY15)	% of treatment target met (FY15) PERSONS	FY17 treatment targets # DISTRICTS	FY17 treatment targets # PERSONS
LF	*0*	*0*	*N/A*	*N/A*	*0*	*N/A*	*N/A*	*0*	*0*
OV	1	17	4[a]	4[b]	1,832,752	1,792,491	97.8%	17	1,486,426
OV	2	15	1[a]	1[b]	959,353	944,453	98.5%	15	1,452,741
SCH	1	33	---[f]	0[d]	2,177,701	2,136,659	98.1%	10	1,246,293
SCH[e]	2	0	*N/A*	*N/A*	0	*N/A*	*N/A*	21	850,447[e]
STH	1	24	2[c]	0[d]	1,293,058	1,286,842	99.5%	28	1,698,638
STH	2	4	0[c]	0[d]	243,195	242,088	99.5%	6	440,548
TRA	0	*0*	*N/A*	*N/A*	*0*	*N/A*	*N/A*	*0*	*0*

** Epi and Program coverage as defined in the workbooks*

*** All data in this table are from FY 2015 MDA. The FY 2016 data were not yet entered at the time this work plan was written.*

[a] *The target epi coverage for onchocerciasis is 65%. Four districts treated annually did not meet epi coverage targets: Amou, Kloto, Wawa, and Cinkassé; One district treated twice a year did not meet epi coverage targets: Binah*

[b] *The target program coverage for onchocerciasis is 80%. Four districts treated annually did not meet program coverage targets: Amou, Kloto, Wawa, and Cinkassé; One district treated twice yearly did not meet program coverage targets: Binah*

[c] *The target epi coverage for STH is 30%. 2 districts = Zio (28%), Kloto (29%)*

[d] *The target program coverage for schistosomiasis and STH is 80%.*

[e] *From 2009 to 2015, schistosomiasis was targeted for treatment one time per year at the most. But according to the results of the 2015 DSA, and WHO guidelines, there will be 73 PHUs in 21 districts that will be targeted for a second round of treatment starting in November 2016. These are PHUs where the prevalence increased in 2015, as compared to the baseline prevalence in 2009.*

[f] *Epidemiological coverage is not a useful measure for schistosomiasis treatment in Togo. With a given district, the target population of the different PHUs can include school-age children, all persons age 5 years and older, school-age children plus women at high risk due to their household activities, or nobody at all. Therefore, there is no concise or useful way to calculate the epidemiological coverage for a district. For schistosomiasis, Togo focuses on the program coverage as the indicator to follow.*

Drug and Commodity Supply Management and Procurement (Drug Delivery, Data Collection, Adverse Events)

Total cost for activities in this section: $30,945

In FY 2016 there were no stock-outs or drug shortages. All drug orders arrived in country well in advance of the MDA.

Togo's drug quantification is based on the village populations enumerated during the MDA; 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. The MOH completes WHO's joint request for selected medicines (JRSM) and HDI reviews and provides input before the form is submitted. The request for FY 2017 praziquantel has already been submitted.

The drug distribution guide, which indicates which populations are to receive which medications in each peripheral health unit, is drawn up by the MOH in close collaboration with HDI. Because of the complexity of Togo's distribution plan, the guide is reviewed by multiple people at the MOH and HDI to ensure accuracy.

Drugs are 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. (Drug Delivery)

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. (Data Collection)

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 Essentials Generiques et des Consommables Medicaux (CAMEG) in Lomé. Once unused drugs are returned to the central level, HDI conducts the physical inventory of drugs with MOH personnel. Damaged drugs and any other waste materials from the MDA are collected and incinerated according to official national procedures.

During the MDA of 2016, the MOH and HDI identified an issue in the management of unused drugs. When there are partially used bottles of medication remaining after the MDA, tablets are combined together to create bottles that have a full complement of tablets. However, under current practices it is possible that pills from different lots may possibly be combined together. This poses a problem because different lots may have different expiration dates, and in the event of an adverse event, the lot number of the tablets involved must be known. In the training for the FY 2017 MDA it will be explicitly stated that drugs can only be combined into the same container if they are from the same lot.

Togo uses the "first to expire, first out" approach for drug utilization, and there have not been instances of drugs expiring before use. However, during the May 2016 MDA, investigation of an adverse event revealed that drugs from a lot number procured in 2014 were being distributed during the 2016 MDA. Although the 2014 lot had not expired, it should have been consumed during the 2015 MDA at the latest. Inventory management practices need to be reviewed to ensure that the "first to expire, first out" practice is being followed at all levels of the supply chain.

The Togo MOH has requested TA for training on supply chain management for personnel at the region, district, and sub-district levels (see Table 6). (STTA)

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 any severe adverse events (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. The latest WHO guidelines on management of SAEs have been incorporated into the Togo system for managing and reporting SAEs.

Reporting of adverse events appears to be working well. During the May 2016 MDA there were two SAEs reported. Both patients made a full recovery. An investigation of the situation was completed and all appropriate paperwork was completed and forwarded to the WHO and drug companies. The investigation of these two SAEs led to the identification of a problem in supply chain management. (Adverse Events)

HDI will support the training of two teams from the NTD Program at the central and regional levels in the logistical management of the MDA medications. (STTA)

Supervision **(FOGs – FOG 1 MDA 2 (November), FOG 3 MDA (April), Rapid Evaluation; HDI MDA – MDA, MDA 2 (Fall))**

Total cost for activities in this section: $446,926

In FY 2017, as in past years, HDI staff will support the NTD program in conducting supervision by attending the training of supervisors and actively participating in supervision in the field during each of the MDAs. Primary responsibility for supervision lies with the districts. The PHU nurse is responsible for assuring effective rollout of the MDAs in their PHU. During the MDAs, district supervisors (three per district) visit PHU dispensaries, receive feedback from PHU nurses, visit any problem areas identified by the PHU chiefs, 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. (FOGs – FOG 1 MDA 2 (November), FOG 3 MDA (April), Rapid Evaluation; HDI MDA – MDA, MDA 2 (Fall)).

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 representative 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.

Field supervision during the April 2017 MDA also includes a rapid evaluation. Central level MOH personnel, based on past experience, conducts its supervision in two distinct phases: at the beginning of the MDA and at the end. The rapid evaluation, conducted at the end of the MDA, collects data on key aspects of implementation that provide a current snapshot of the distribution process that allows immediate intervention if problems are identified. The rapid evaluation questionnaire is used to ask individuals who are targeted for treatment whether they have received the drugs, for what reasons (if any) they did not receive the drugs (allows identification of unreported stock-outs), whether there were any adverse effects (allows identification of mild adverse effects), where they received the drugs (to confirm that distribution is occurring door-to-door), and where they heard about the MDA (provides information on the effectiveness of the various methods of social mobilization). (FOGs – FOG 3 Rapid Evaluation, HDI MDA – Rapid Evaluation)

At the end of the MDA, a team of supervisors (one person from the central level and the regional focal point for NTDs) 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. (Data Collection)

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 (STTA)

Total cost for activities in this section: END in Africa budget

Short-term technical assistance will be requested for updating the TIPAC, SCM, advocacy and stakeholder outreach, using the integrated NTD database and DQA tool, ArcGIS, and for technical input on onchocerciasis elimination at one OEC meeting.

Table 6: Technical Assistance request from End in Africa

Task-TA needed (Relevant Activity category)	Why needed	Technical skill required; (source of TA (CDC, RTI/HQ, etc))	Number of Days required and anticipated quarter	Funding source (e.g., country budget, overall budget, CDC funding)
Internal support (e.g., RTI/HQ, USAID, CDC)				
Follow-up training from Deloitte to update the TIPAC for FY17 (Strategic Planning)	The NTDP would like assistance in the analysis and utilization of the data emerging from the TIPAC	Expertise on TIPAC (Deloitte)	1 week, Q1 of FY17	END in Africa overall budget
Capacity building in supply chain management	The NTDP requests training on supply chain management to improve	Expertise on supply chain management (FHI360)	1 week, Q2 of FY17	END in Africa overall budget

	the movement and flow of drugs and data at all levels, with an emphasis on the district level			
Organization of a stakeholder meeting for mobilizing resources	The NTDP would like technical assistance on advocacy and stakeholder outreach	Expertise on advocacy (Deloitte)	5 days, Q3 of FY17	END in Africa overall budget
Training on WHO Integrated NTD database (M&E)	The NTD Program would like to improve on current data management strategies and integrate data management across all individual NTD programs	Expertise in WHO Integrated NTD database (FHI360)	2 weeks, Q1 of FY17	END in Africa overall budget
Training on NTD Data Quality Assessment (DQA) Tool	The NTD Program would like to understand and use the DQA tool to assist with program M&E	Expertise on NTD DQA (FHI360)	2 weeks, Q1 of FY17	END in Africa overall budget
Training on ArcGIS and graphic presentation of data	The NTD Program, would like to have the capacity to independently graph their epi and entomology data, particularly to help with onchocerciasis elimination	Expertise in training on ArcGIS; can train in French (FHI360)	Five days, Q1 of FY17	END in Africa overall budget
External support (e.g., hired consultants)				
External expert participation at Togo's OEC meeting	Although Togo has many highly accomplished oncho experts, additional expertise from WHO, MDP and entomology and oncho elimination experts is needed at one OEC meeting during the year	Expertise in onchocerciasis and onchocerciasis elimination (WHO/CDC, MDP, Carter Center)	Travel support for four people x 1 week, Q3 of FY17	Country budget

M&E (Epi Summary, OV16 & Schisto, Supplemental budget - Ento Summary, STTA)

Total cost for activities in this section: $210,570 plus $28,167 in supplemental budget

In FY 2017 the priority areas for M&E include disease specific assessments (DSA) for onchocerciasis, training on and launch of WHO's integrated NTD database, and preparation and implementation of a Data Quality Assessment (DQA).

Disease-Specific Assessments (DSA)

An integrated DSA for schistosomiasis and STH and a TAS for LF were conducted in 2015, so no additional DSA are needed for these diseases in FY 2017. While additional trachoma mapping may be needed, a DSA is not indicated. LF TAS are the only DSA conducted in Togo that have an associated critical cutoff, and all TAS to date in Togo met these cutoffs, therefore no DSA are listed in Table 7.

For onchocerciasis, DSA to date have consisted of skin snip surveys, with Ov16 RDT in late 2015, in approximately 300 villages that are assessed on a rotating basis every three years. Because the survey in late 2015 sampled high-risk villages and utilized the Ov16 RDT, rather than ELISA, results from this approach should not be judged against the WHO threshold established in the 2016 guidelines for onchocerciasis elimination, so the surveys are not represented in Table 7. The OEC has made recommendations for specific DSA needed to move forward with elimination activities; these DSA will cover a broader geographic area than recent investigations. Additionally, a stop-MDA assessment will be implemented in Maritime region and a rapid assessment using Ov16 RDT will be implemented in the districts of Cinkassé, Tone, and Kpendjal to evaluate whether those districts are ready for a full scale stop-MDA assessment using Ov16 ELISA. (Epi Summary, Supplemental budget - Ento Summary)

Data Quality Assessment (DQA)

Although there is routine evaluation of the MDA data every year, in FY 2017 an effort will be made to transition this activity away from HDI, which has historically provided significant support in this area, to the MOH. The DQA tool provides a standardized means of evaluating the quality of the NTD Program's data. This tool will also assist with tracking improvements in the program and identifying persistently problematic areas, neither of which are currently rigorously tracked. The MOH will receive training on this tool and will implement it in FY 2017. (STTA)

Management of MDA data:

HDI will support the MOH in contracting with external data personnel for entering and cleaning the MDA data in 2017 while Togo is expanding its data management capacity through the DHIS (Demographic Health and Information System). (Data Collection)

Other M&E activities

The NTD Program will be trained on and will launch the use of the WHO's National NTD Database, which, with the DQA tool, will improve data quality and program monitoring and evaluation. (STTA)

There continue to be issues with the denominator for onchocerciasis. In FY 2017, generating a list of villages targeted for ivermectin treatment, and integrating that list with the existing drug distribution guide for schistosomiasis and STH, should improve prospective estimates of onchocerciasis target populations and resolve denominator issues. This will be a priority activity in FY 2017, as this information will feed directly into the Integrated NTD Database and DQA activities.

Finally, a specific M&E need in FY 2017 is to investigate the reason for the persistent high prevalence of schistosomiasis in Ogou district and of STH in Ogou and Haho districts. Although the 2015 DSA for STH and schistosomiasis demonstrated a significant decrease in the overall prevalence of both diseases after five years of MDA, these two districts did not experience the same decrease and further investigation is needed to determine why. The MOH has requested that HDI first assist in analyzing the results of the 2015 coverage validation survey, which was conducted in three districts, including Haho. Coverage estimates from this survey may indicate the source of the problem in Haho, but additional investigations will be needed. HDI will provide TA for this work. (OV16 & Schisto - SCH/STH Evaluation Haho/Ogou)

Table 7: Reporting of DSA supported with USAID funds that did not meet critical cutoff thresholds*

NTD	Number of endemic districts	Type of DSA carried out (add extra rows as needed for each type)	Number of DSAs conducted with USAID support	Number of EU that did not meet critical cutoff thresholds
Lymphatic filariasis	8	0	3[a]	0
Onchocerciasis	32	0	0	N/A
Trachoma	0	0	0	N/A

[a] Three TAS with four evaluation units each, and two to three districts per evaluation unit; data are from 2015

Table 8: Planned Disease-specific Assessments for FY17 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*	*7*	*Stop-MDA assessment*	*Ov16 ELISA*
Onchocerciasis	*32*	*3*	*Rapid evaluation to assess readiness for stop-MDA assessment*	*Ov16 RDT*

Planned FOGs to local organizations and/or governments

TABLE 9 LISTS THE THREE FIXED OBLIGATION GRANTS (FOGS) TO THE TOGO MOH THAT ARE PLANNED FOR FY 2017.

Table 9: Planned FOG recipients—include for all subpartners as well.

FOG recipient (split by type of recipient)	No. of FOGs	Activities	Target Date to USAID
Togo MOH	*2*	• *Social mobilization activities and training of nurses and CDDs in advance of the April 2017 MDA* • *Planning and implementation of the April 2017 MDA, including the development of a detailed distribution plan, and submission of a final report of the MDA* • *Rapid evaluation during the April 2017 MDA*	*Jan 2017*
Togo MOH	*1*	• *Implementation of the November 2016 MDA*	*Nov 2016*

Cross-Portfolio Requests for Support

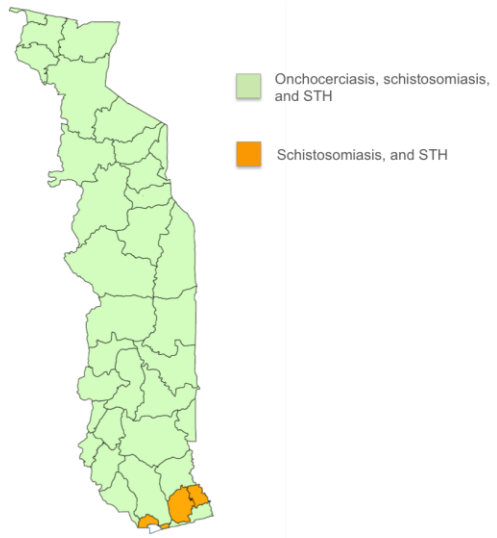
The most significant gap in Togo's program remains MMDP: surgeries for hydrocele and trichiasis, and case management of lymphedema. Togo obtained funding for surgeries from the Bill & Melinda Gates Foundation, but additional funding is needed, and options for additional funding are being explored.

Table 10: Cross-Portfolio Requests for Support

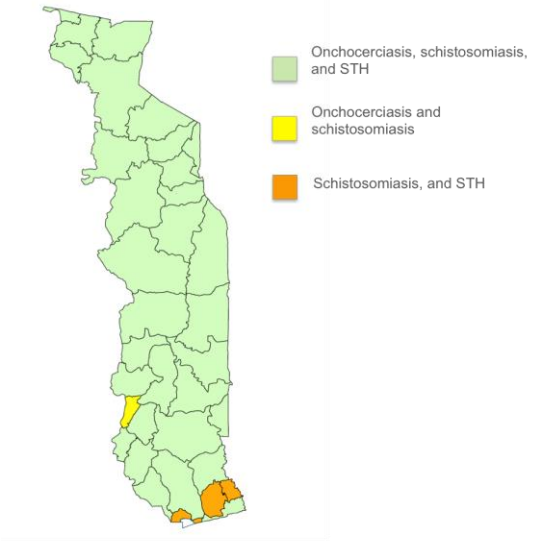
Identified Issue/activity for which support is requested	Which USAID partner would likely be best positioned to provide this support?	Estimated time needed to address activity
Trichiasis surgeries		One year
Hydrocele surgeries		One year
LF MMDP activities		Ongoing

Maps

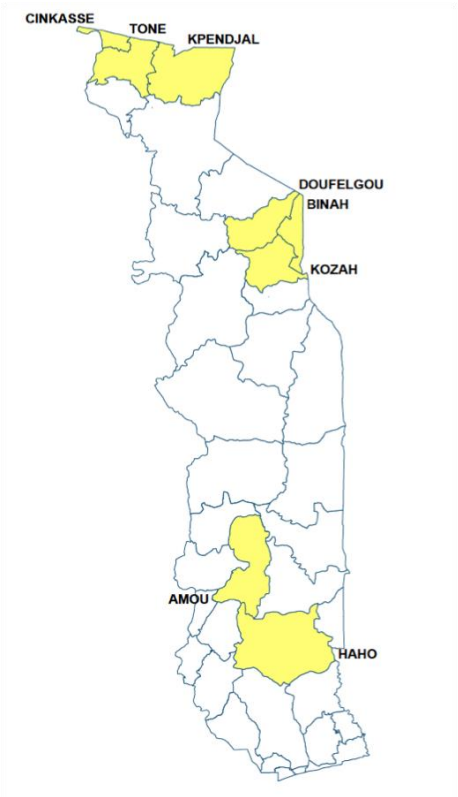
The following maps show disease presence by district, districts undergoing MDA with USAID support, and previously endemic LF districts.



Togo: Disease presence by district



Togo: Districts targeted with MDA with USAID funding

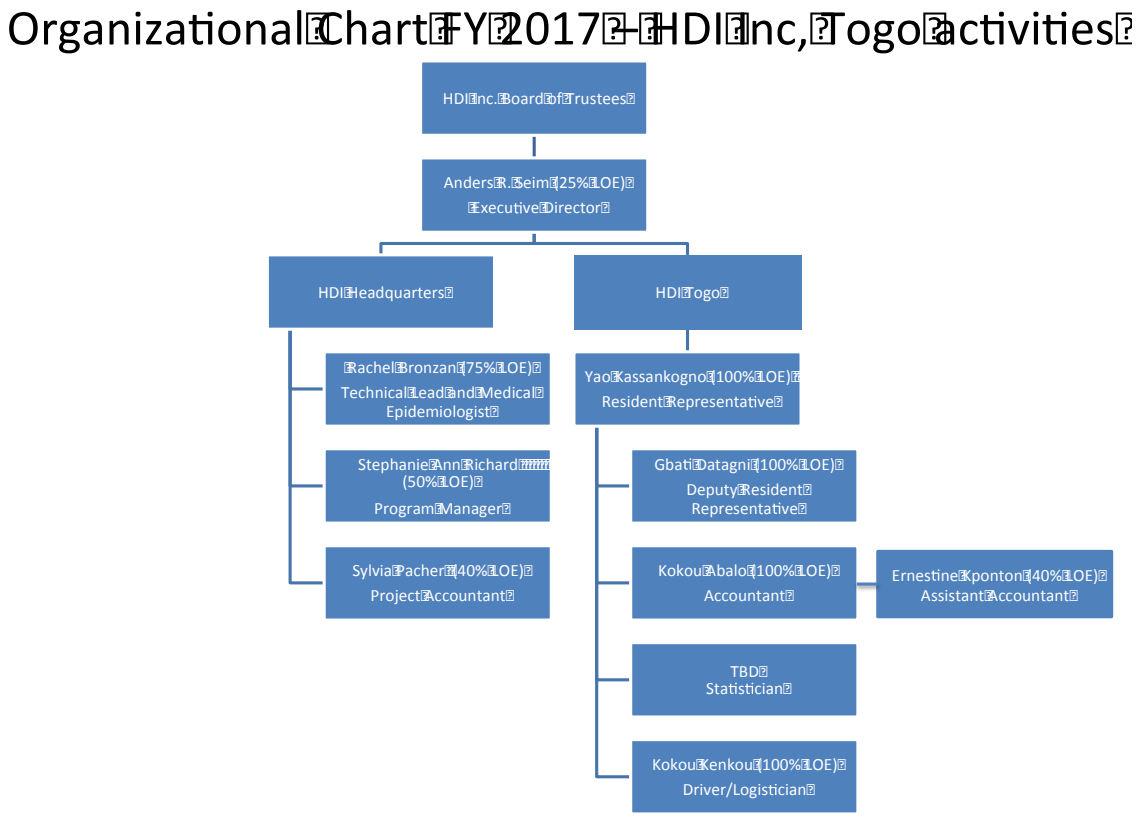


Togo: Previously endemic LF districts – all eight districts have passed three TAS

APPENDICES

1. Country staffing/HDI 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

Appendix 1. HDI Organizational Chart



Annex 2: Work Plan Timeline

Timeline of Major Activities: Togo integrated NTD program Oct 2016 – Sep 2017

2015-2016	*Month (October-September)*											
Activity	O	N	D	J	F	M	A	M	J	J	A	S
Meeting of National Organizing Committee	X	X	X	X	X	X	X	X	X			
Develop tools for managing/supervising MDA		X	X	X								
Finalize Microplans, Budget, Treatment Plan					X							
Receive medications					X	X						
Revise messages for social mobilization					X							
Produce social mobil. messages/materials					X							
Distrib. social mobil. materials/messages[1]					X							
Comm. Sensitization high prev oncho villages					X							
Implement social mobilization activities/IEC[2]	X[2]					X[3]	X[3]					
Distrib. supplies and drugs to districts & PHUs	X[2]					X[3]						
Reproduce/distribute any needed dose poles			X	X	X							
Print flip charts to replace any lost/damaged			X	X	X							
Revise and print training documents				X	X							
Briefing of supervisor for second round	X											
Training of central, regional, district trainers						X						
Training of PHU nurses						X						
Training of CDDs						X						
Official launch of MDA							X[3]					
MDA	X[2]						X[3]					
Supervision of MDA, all levels	X[2]						X[3]					
Surveillance for adverse effects	X[2]						X[3]					
Rapid assessment							X[3]					
Tally, synthesize, and validate data at PHUs		X[2]						X[3]				
Meetings to summarize results at all levels								X[3]	X[3]			
Collect data, drugs, and financial documents				X[2]					X[3]			
Collect and validate data forms				X[2]					X[3]			
Enter and analyze data at central level				X[2]					X[3]			
M&E – Generate report of MDA				X[2]					X[3]			
M&E – Post-MDA review meeting				X						X		
Onchocerciasis stop MDA survey							X					
Onchocerciasis rapid evaluation						X						
Onchocerciasis surv. – higher prev zones	X	X				X	X	X				
Onchocerciasis entomological surveys	X	X	X						X	X	X	
Program review/microplanning meeting					X							
NTD Secretariat meetings	X			X			X			X		
Onchocerciasis elimination committee mtgs		X				X					X	
Work Planning meeting for FY2018								X				
Finalize drug applications for FY2018						P[4]	I[4]	A[4]				
Monthly Financial Reporting	X	X	X	X	X	X	X	X	X	X	X	X
VAT Report							X					
Cost Share Reporting						X						X
Semi-annual reports						X						X

[1]Town criers, local radio, local TV, press releases; [2]for October MDA – ivermectin, albendazole and praziquantel in highest prevalence districts; [3]for April MDA – ivermectin, albendazole and praziquantel nationwide as indicated; [4]P=praziquantel, I=ivermectin, A=albendazole

Appendix 3. Work plan deliverables

HDI will provide the following deliverables in FY 2017.

Mass Drug Administrations

- April-May 2017: One nationwide mass drug administration of ivermectin (IVM), praziquantel (PZQ), and albendazole (ALB) for onchocerciasis, schistosomiasis, and soil transmitted helminths (STH), respectively, to all persons in all endemic areas according to disease prevalence, WHO guidelines, and Togo's Five Year strategic Plan for NTDs. Targets are:
    - Onchocerciasis – 2,939,167 people/32 districts;
    - Schistosomiasis – 2,096,940 people/31 districts;
    - STH – 2,139,186 SAC/34 districts;
    - 100% geographic coverage of at-risk areas.
- October-November 2016: One mass drug administration of IVM, PZQ and ALB in those districts with prevalence warranting a second round of mass drug administration according to WHO guidelines and disease prevalence. Note that ALB distribution plans will be amended before the October 2016 MDA based on the results of the STH disease-specific assessment currently being analyzed. Targets are:
    - Onchocerciasis – 1,452,741 people/15 districts;
    - Schistosomiasis – 850,447 people/21 districts;
    - STH – 257,205 SAC/6 districts.

Surveillance, Monitoring and Evaluation

Onchocerciasis

- Epidemiological evaluation in 97 villages in in areas of potentially higher onchocerciasis prevalence
- Epidemiological evaluation for stop-MDA decision in all 7 districts of Maritime region
- Rapid evaluation in Cinkasse, Tone, and Kpendjal districts
- If funding is available: Entomological evaluation in 24 sites

Strategic Planning

- Support quarterly NTD secretariat meetings
- Three meetings of the onchocerciasis elimination committee; one with international experts
- One work planning meeting (with MOH, FHI360, USAID, and other partners)
- Review and revise NTD five-year strategic plan
- Review and revise, according to new WHO guidelines, the Five Year Strategy for Elimination of Onchocerciasis
- Two cross-border meetings (Ghana and Benin) to address cross-border issues, particularly for onchocerciasis
- Meeting to support development of NTD Program Annual Operational Plan

Training

- Train more than 11,000 persons on MDA implementation;
- Train onchocerciasis field workers on entomologic (13 people) and epidemiologic (40 people) field practices, and 6 laboratory personnel on pool screen PCR, in preparation for scaled-up activities for onchocerciasis elimination;
- If funding is available, hold refresher training on USAID accounting practices for district, regional, and central level accountants (50 people).

Appendix 4. Table of USAID-supported Regions and Districts IN FY17

	Region	Health Districts	OV MDA	SCH MDA	STH MDA	OV epidemiological surveillance	OV entomological surveillance
1	*Centrale*	*Blita*	X	X	X	X	X
2		*Sotouboua*	X	X	X	X	X
3		*Tchamba*	X	X	X	X	
4		*Tchaoudjo*	X	X	X		
5	*Kara*	*Assoli*	X	X	X		
6		*Bassar*	X	X	X	X	X
7		*Binah*	X	X	X		
8		*Dankpen*	X	X	X	X	X
9		*Doufelgou*	X	X	X	X	
10		*Keran*	X	X	X	X	X
11		*Kozah*	X	X	X	X	X
12	*Lomé*	*District 1*					
13		*District 2*					
14		*District 3*					
15		*District 4*					
16		*District 5*					
17	*Maritime*	*Avé*	X	X	X	X	
18		*Bas Mono*		X	X	X	
19		*Golfe*		X	X	X	
20		*Lacs*	X	X	X	X	
21		*Vo*		X	X	X	
22		*Yoto*	X	X	X	X	X
23		*Zio*	X	X	X	X	X
24	*Plateaux*	*Agou*	X	X	X	X	
25		*Akébou*	X	X	X		
26		*Amou*	X	X	X	X	X
27		*Anie*	X	X	X	X	X
28		*Danyi*	X	X	X		
29		*Est Mono*	X	X	X		
30		*Haho*	X	X	X	X	X
31		*Kloto*	X	X	X	X	
32		*Kpele*	X	X	X		
33		*M. Mono*	X	X	X		
34		*Ogou*	X	X	X	X	X
35		*Wawa*	X	X	X	X	X
36	*Savanes*	*Cinkassé*	X	X	X	X	
37		*Kpendjal*	X	X	X	X	X
38		*Oti*	X	X	X	X	X
39		*Tandjoaré*	X	X	X	X	
40		*Tone*	X	X	X	X	X

Appendix 8. Travel Plans

International travel during FY 2017 includes the following:

Name	Number trips	Travel from	Travel to	Purpose
Rachel Bronzan, Technical Lead	4	Seattle, Washington	Lome, Togo	- Work plan meeting FY 2018 - Onchocerciasis elimination meeting in January 2017 - Onchocerciasis field work in March 2017 - LF Elimination Celebration
	1	Seattle, Washington	TBD	NGDO Meeting in September 2017
	1	Seattle, Washington	Europe	GAELF Meeting/NTD Partners Forum, April 2017
Stephanie Richard, Program Manager	1	Rockville, MD	Lome, Togo	Work plan meeting FY 2018
	1	Rockville, MD	TBD	NGDO Meeting in September 2017
Sylvia Pacher, Accountant	1	Rockville, MD	Lome, Togo	Accounting technical assistance
Anders Seim, Executive Director	2	Oslo, Norway	Lome, Togo	- Onchocerciasis elimination meeting in January 2017 - Preparations for integrated April 2017 MDA
	1	Oslo, Norway	Europe	GAELF Meeting/NTD Partners Forum, April 2017
	1	Oslo, Norway	Atlanta, GA	ASTMH, November 2016
Yao Kassankogno, HDI Togo Resident Representative	1	Lome, Togo	Atlanta, GA	ASTMH, November 2016
Michel Datagni, HDI Togo Deputy Resident Representative	1	Lome, Togo	Atlanta, GA	ASTMH, November 2016
	1	Lome, Togo	TBD	Management training
Ministry of Health Personnel (8)	1	Ghana	Togo	Cross-border meetings
Ministry of Health Personnel (8)	1	Benin	Togo	Cross-border meetings
Onchocerciasis experts (4)	1	TBD	Togo	Onchocerciasis elimination meeting in January 2017