

TOGO MALARIA PROFILE

I. ABOUT

Launched in 2005, the [U.S. President's Malaria Initiative \(PMI\)](#) supports implementation of malaria prevention and treatment measures as well as cross-cutting interventions. PMI's 2021–2026 strategy, [End Malaria Faster](#), envisions a world free of malaria within our generation, with the goal of preventing malaria cases, reducing malaria deaths and illness, and eliminating malaria in PMI partner countries. PMI currently supports 27 countries in Sub-Saharan Africa and three programs across the Greater Mekong Subregion in Southeast Asia to control and eliminate malaria. Togo began implementation as a PMI focus country in FY 2023. Please see the Togo Malaria Operational Plan on [PMI.gov](#) for more information on PMI's approach and investments.

II. CONTEXT

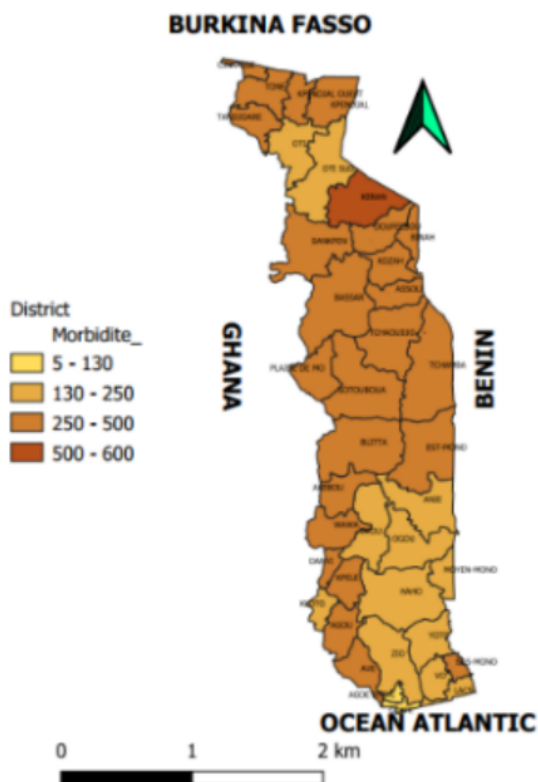
Table 1. General Demographics and Malaria Situation

Population	8,095,498 (2022 General Population and Housing Census)
Population at risk of malaria	8,095,498 (National Strategic Plan 2023–2026)
Malaria prevalence	35.5 percent (rapid diagnostic test [RDT] and microscopy, Malaria Indicator Survey [MIS], 2020)
Malaria incidence/1,000 population at risk	275 (2022 National Malaria Control Program [NMCP] Report/Strategy)
Peak malaria transmission	Perennial in the southern part of the country; July–November in northern districts

STRATIFICATION

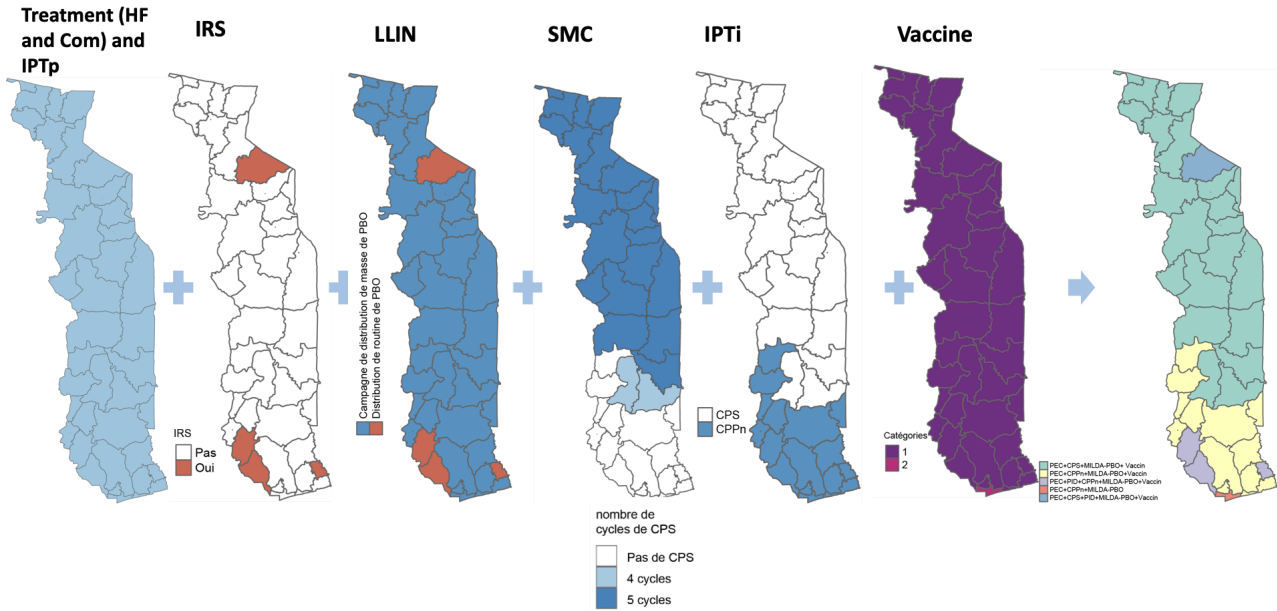
Figure 1 shows a district-level map of the malaria burden in Togo from the National Malaria Control Program's 2021 annual report. The malaria morbidity strata are grouped by the number of malaria cases reported from health centers and community health workers.

Figure 1. Malaria Morbidity Stratification Map, 2021



A stratification exercise for Togo was carried out in March 2023 with assistance from the World Health Organization's Global Malaria Programme (WHO/GMP). This exercise was used as the basis for Togo's National Malaria Strategic Plan 2023–2026. In addition to reexamining the epidemiological data to stratify malaria prevalence, incidence, and mortality, this exercise produced models to suggest ideal intervention mixes to maximize impact. Results of this exercise are shown in Figure 2.

Figure 2. District-Level Maps of Recommended Targeted Malaria Control Interventions

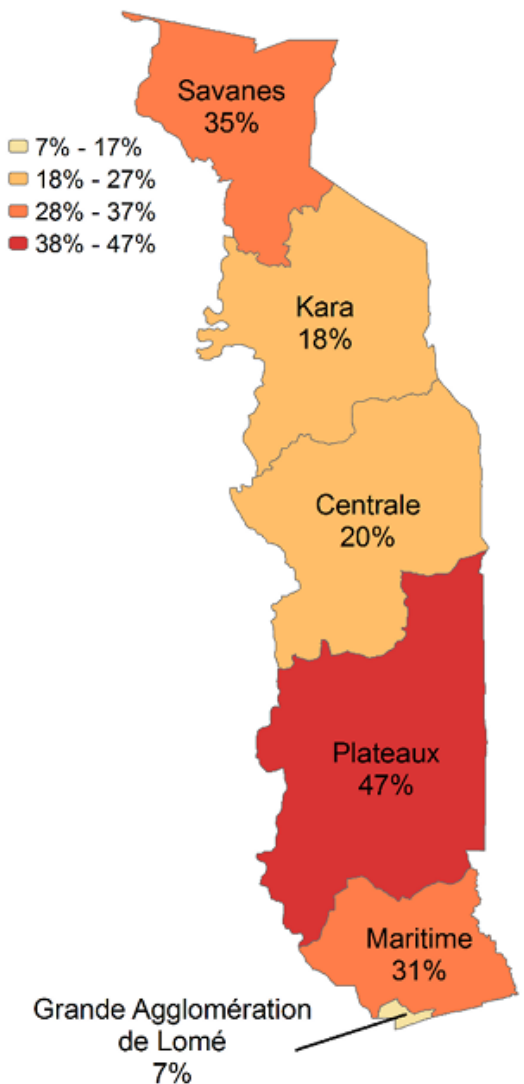


Source: Analysis of the stratification and mix of interventions in Togo in 2023, supported by WHO/GMP.

Malaria prevalence is measured every three to five years in nationally representative household surveys. Figure 3 shows maps of regional malaria prevalence estimates among children aged 6–59 months from 2017 and 2020 malaria indicator surveys as measured by microscopy. In this case, all regions except Kara showed increases in prevalence between the two survey years. Figure 4 shows malaria prevalence estimates at the district level over all years (since 2000) using geospatial estimation methods. These estimates adjust for the combined effect of malaria control interventions implemented in the past as well as environmental and climatic covariables.

Figure 3. Regional Malaria Prevalence Maps from Household Surveys, 2017 and 2020

2017 MIS:
Malaria prevalence among
children 6–59 months as measured
via microscopy



2020 MIS:
Malaria prevalence among
children 6–59 months as measured
via microscopy

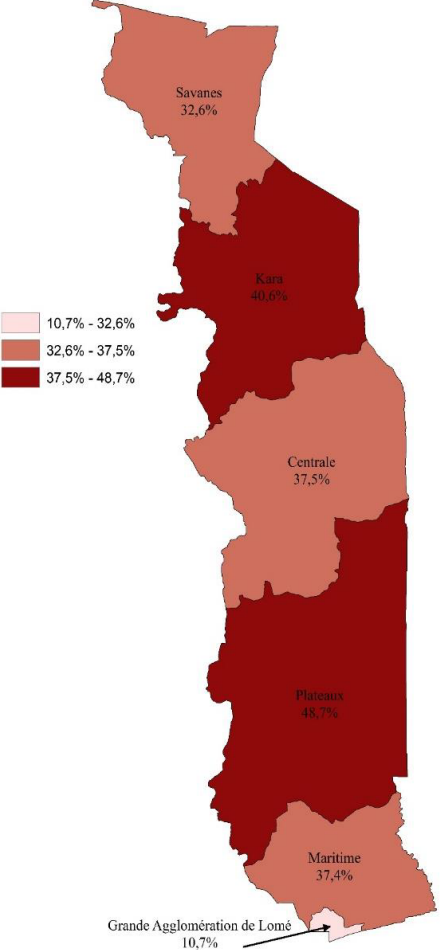
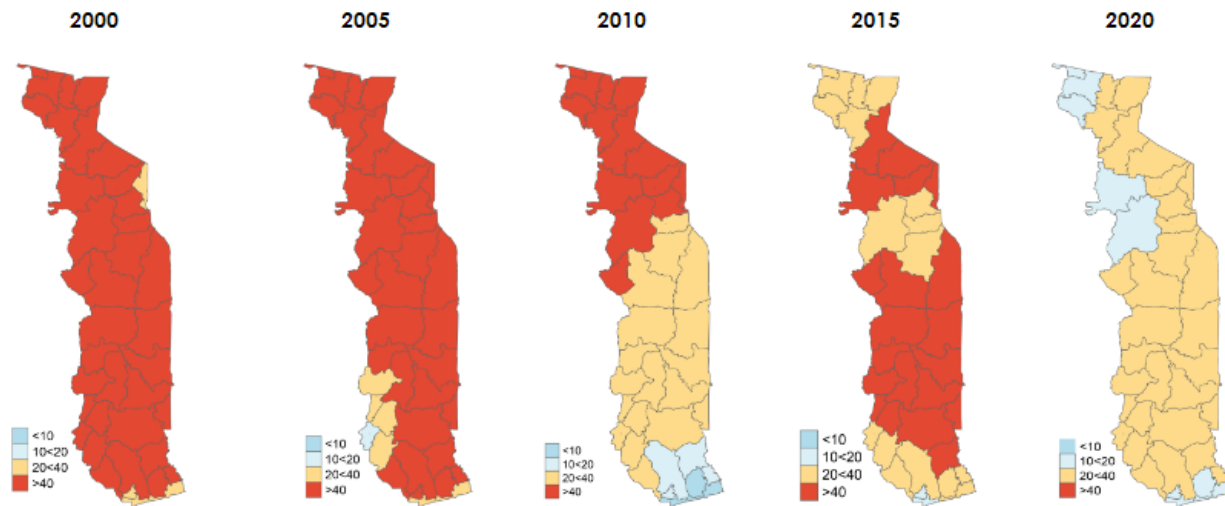
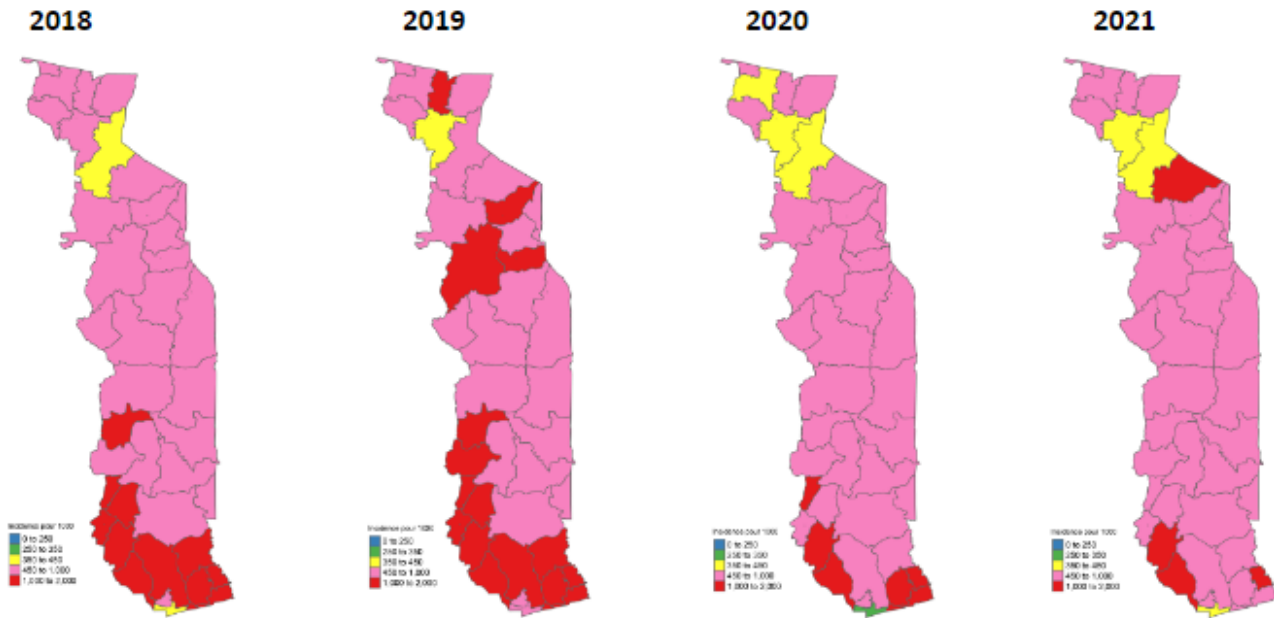


Figure 4. District-Level Maps of Malaria Prevalence as Estimated by the Malaria Atlas Project Using Geospatial Estimation Methods, 2000–2020



Another outcome measure that is an important component of malaria risk stratification is incidence. Figure 5 shows a series of maps of malaria incidence from 2018–2021, created with WHO/GMP support during the stratification exercise. The estimates are adjusted for malaria testing rates, care seeking behaviors, and data completeness.

Figure 5. District-Level Malaria Incidence Maps, 2018–2021



The seasonality of malaria transmission is an important factor to consider when optimizing investments in malaria control. Figure 6 shows monthly patterns of malaria cases reported by health facilities (blue line), by community health workers (red line), and total cases (green line), from 2019 to 2021. The peak in cases in the last half of the year is evident from this figure, as is the important contribution of CHW to diagnosing and reporting (and treating) malaria cases in Togo.

Figure 6. Seasonality of Malaria Transmission: Monthly Malaria Cases Reported by Health Facilities by CHW and Overall, 2019–2021

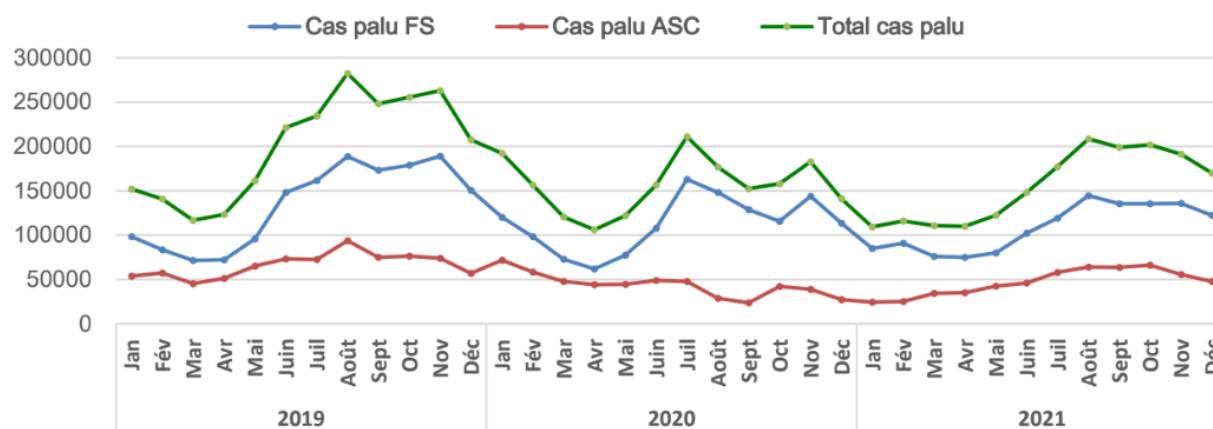


Table 2. Malaria Parasites and Vectors

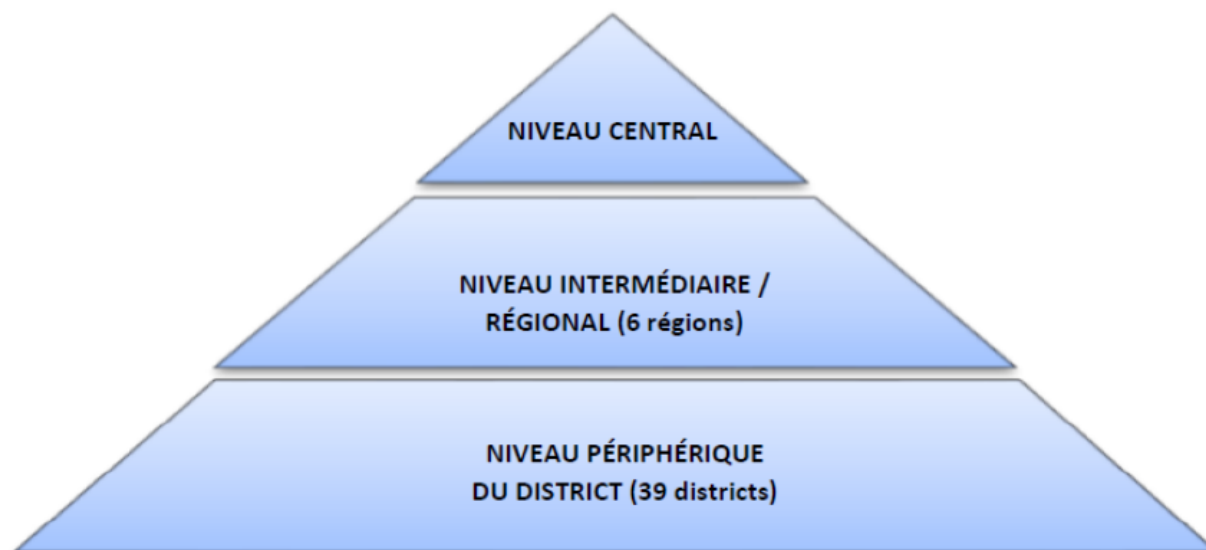
Principal malaria parasites	The main pathogen of malaria in Togo is <i>P. falciparum</i> (94.6 percent). Secondarily, <i>P. malariae</i> is at 3 percent, and <i>P. ovale</i> is at 2.4 percent (Status of circulating plasmodial species in Togo, 2019).
Principal malaria vectors¹	The two main vectors are <i>An. coluzzii</i> and <i>An. gambiae</i> . <i>An. coluzzii</i> is the most widespread species in Togo, followed by <i>An. gambiae</i> . The secondary vectors are <i>An. arabiensis</i> and <i>An. funestus</i> , observed during the rainy season and in clear waters, and <i>An. melas</i> , which is found in areas with brackish water (southeastern Togo). The major malaria vector in Togo— <i>An. gambiae</i> , <i>s.l.</i> —is resistant to the four major classes of insecticide used in malaria control (pyrethroid, organochlorine, carbamate, and organophosphate). Pyrethroid resistance in particular is widespread, with high resistance intensity at many sites characterized with metabolic-based resistance mechanisms. The synergist PBO partially restored susceptibility to pyrethroids. There is no information on the susceptibility status of <i>Anopheles</i> to chlorfenapyr, a key component of dual active ingredient insecticide-treated net.

¹ See the entomological monitoring section of the MOP for more details on vector bionomics and insecticide resistance and the indoor residual spraying section for details on residual efficacy.

COUNTRY HEALTH SYSTEM

Togo's health system is organized according to a three-level pyramid structure as shown in Figure 7.

Figure 7. Organization of the Health System in Togo



Source: National Public Health Strategy, 2022–2027

Central level (*niveau central*): Office of the minister, general secretariat, directorates, divisions and attached services, and national reference and university hospitals.

Mission: Definition of and monitoring and control of health policies and standards, development of training plans, training modules, and career professionals.

Intermediate level (*niveau intermédiaire/régional*): Regional health directorates, regional specificities, and regional hospitals.

Mission: Supervision, monitoring implementation of standards and policies from the central level.

Peripheral level (*niveau périphérique du district*): Prefectural health directorates, district hospitals, and peripheral care units.

Mission: Operationalization (implementation of interventions).

Three categories of health zones exist: health regions (6), health prefectures/districts (39), and health communes (117). Thus, at the decentralized level, there is the intermediate level, the regional health directorates (directed by the regional management teams) and the local/peripheral level, the prefectural health directorates (directed by the district management teams).

Peripheral-level care is structured around three levels: (1) the community health worker (CHW), who provides care at the family and community level and who is called on to interface between the community and the health services; (2) the peripheral care unit as the basis of the care system and from which local activities are carried out in a fixed strategy and outreach to the populations; (3) the district hospital, which constitutes the first referral level. The intermediate level comprises regional hospitals (regional hospital centers). Tertiary health care is provided in three university hospital centers and in specialized reference hospitals.

Supply Chain for Drugs and Other Health Care Products

Togo has a drug supply system run by CAMEG TOGO and its six regional supply pharmacies based in Lomé, Tsévié, Atakpamé, Sokodé, Kara, and Dapaong. The peripheral level of the public pharmaceutical circuit (district level) is not yet structured and its organization varies according to the health regions; the distribution of health products for malaria control follows the same circuit with resupply occurring on a quarterly basis (when stocks are available at the central level). Health facilities receive their commodities from district depots, and community health workers are resupplied on a quarterly basis from their health centers of affiliation. At the regional level, there are regional committees for the management of medical inputs that ensure the quantification of needs for malaria, HIV, and tuberculosis.

From 2017 to 2021, the availability of drugs at health facilities has improved slightly. Thus, the percentage of health establishments without stock shortages of at least one tracer drug (during the last three months) has increased from 39 percent in 2012 to 58 percent in 2021.

Health Care Financing

The resources devoted to health in Togo, according to health accounts and the Global Health Expenditure Database (GHED) come mainly from four essential sources:

1. Public (government) resources, which represented approximately 20 percent of health expenditures in 2020;
2. The external resources of technical and financial partners through bilateral and multilateral agreements represent approximately 10 percent of health expenditures in 2020;
3. Health expenditures in the form of direct household payments correspond to 60 percent of total health expenditures; and
4. Health resources from other private sources, nongovernmental organizations, and health insurance is about 10 percent.

Domestic financing represents 90 percent of 2020 health expenditures, largely dominated by direct payments, although public spending is on the rise. From 2016 to 2023, the national budget allocated to health has been variable, from 6 percent in 2016 to 8 percent in 2023, peaking in 2020 in connection with the effort to fight COVID-19.

National Health Information Systems

The collection of data from the national health information system is ensured using the District Health Information System-2 (DHIS2) platform; its operational manual for procedures describes the process of data collection and submission of reports. This platform is used in all the health districts of the country and includes data down to the community level.

The rates of completeness and promptness of periodic reports are still very variable from one year to another (91 percent in 2017, 89 percent in 2021, and peaking at 96.5 percent in 2018).

Overall, there appears to be a good mastery for filling out the tools and the data quality control system by the various actors. This progress has made it possible to regularly produce the annual health statistics presenting quality data broken down by health district.

In addition to the key indicators of the National Malaria Control Program (NMCP), which are taken into account in the DHIS2, the program has a monitoring and evaluation unit that ensures the quality of the data through monitoring, the preparation of performance reports, the organization of reviews with the participation of stakeholders, and other means.

OTHER CONTEXTUAL INFORMATION

Terrorist activity in West Africa in recent years has become a major destabilizing factor in the region. After Mali, Niger, Burkina Faso, and Nigeria, the terrorist threat has recently evolved into northern Togo, Benin, and Côte d'Ivoire. Terrorist activity could affect security conditions, and therefore malaria interventions and food supplies, in northern Togo. There are programs in Togo addressing food insecurity and internally displaced persons.

III. NMCP STRATEGIC PLAN 2023–2026

Vision: Togolese communities and families are freed from the burden of malaria by 2030 to contribute efficiently to the country's development.

Mission: Eliminate malaria by ensuring universal access to malaria interventions.

Guiding Principles and Values

The guiding principles of the malaria control program are based on:

- Good governance;
- Community participation;
- Integration;
- Decentralization;
- Partnership;
- Shared planning, coordination, monitoring, and evaluation frameworks; and
- The multisectoral nature of the fight against malaria.

Priorities and Strategic Orientation

The strategic orientation of the NSP 2023–2026 responds to the dynamics of universal access in terms of prevention and case management of malaria. It is consistent with the strategic axes of the National Health Development Plan (*Plano Nacional de Desenvolvimento Sanitário*, or PNDS) 2023–2027, which are derived from the Sustainable Development Goals, particularly axis 1: the acceleration of the reduction of maternal, neonatal, and infant-child mortality and strengthening of family planning and adolescent health; axis 2: strengthening the fight against communicable diseases; and axis 5: strengthening the health system toward universal health coverage, including community health.

Goal

Contribute to improving the health status of the population by significantly reducing the burden of malaria by 2026.

Objectives

The objectives of the NSP 2023–2026 are in line with the guidelines of WHO's Global Technical Strategy for Malaria 2016–2030 and the ECOWAS strategy. They are to:

- Reduce the incidence of malaria by at least 65 percent compared with 2022;
- Reduce the malaria mortality rate by at least 65 percent compared with 2022; and
- Strengthen management capacities in the fight against malaria at all levels.

Expected Outcomes

The expected outcome arising from the objectives are:

- At least 80 percent of the population at risk of malaria slept the previous night under an insecticide-treated mosquito net;
- At least 85 percent of children under the age of five at risk of malaria slept the previous night under an insecticide-treated mosquito net;
- At least 85 percent of pregnant women at risk of malaria slept the previous night under an insecticide-treated mosquito net;
- At least 76 percent of pregnant women at risk of malaria received at least three doses of intermittent preventive treatment during antenatal care during their last pregnancy;
- At least 96 percent of children aged 3–59 months received complete seasonal malaria chemoprevention treatment (four or five cycles) during the high-transmission season in the targeted areas;
- At least 40 percent of children under the age of five with a fever in the past two weeks had a blood sample for confirmatory malaria testing from their finger or heel;
- At least 80 percent of children under the age of five who had malaria in the last two weeks preceding the survey received an artemisinin-based combination therapy (ACT) according to national guidelines among those who received an antimalarial;

- At least 77 percent of those with confirmed severe malaria cases hospitalized in health facilities received antimalarial treatment according to national guidelines; and
- At least 62 percent of women between the ages of 15 and 49 mentioned mosquito bites as the only way to contract malaria.

National Malaria Control Strategies and Interventions by Objective

1. Reduce the incidence of malaria by at least 65 percent compared with 2022

- Vector control
 - Universal access to insecticide-treated nets (ITNs);
 - Indoor residual spraying (IRS);
 - Insecticide-resistance management;
 - Other vector control measures (e.g., larval control and environmental management); and
 - Entomological surveillance/quality control.
- Malaria prevention during pregnancy
 - Intermittent preventive treatment with SP; and
 - Routine distribution of ITNs to pregnant women.
- Seasonal malaria chemoprevention in children aged 3–59 months with Sulfadoxine-pyrimethamine + amodiaquine (SPAQ)
- Intermittent preventive treatment of infants
- Malaria vaccine
- Mass treatment in targeted areas

2. Reduce the malaria mortality rate by at least 65 percent compared to 2022

- Parasitological diagnosis
 - Diagnosis in health facilities (RDT and microscopy);
 - Community-level diagnosis (RDT); and
 - Quality assurance/quality control of laboratories.
- Malaria treatment
 - Treatment of simple and serious cases in health facilities: ACT, artesunate injection, artemether injection, and quinine (injection or oral); and
 - Treatment of simple cases at community level: ACT.
- Pharmacovigilance
 - Notification of adverse reactions; and
 - Management of adverse effects.
- Antimalarial efficacy monitoring (therapeutic efficacy studies)

3. Strengthen management capacities in the fight against malaria at all levels

- Programmatic management of malaria at multiple levels
 - Strengthening of institutional capacities and program managers, including logistics
 - Human resources to support the fight against malaria
 - Planning and implementation of interventions
 - Partnership: partner mapping, technical assistance, resource mobilization, and cross-border actions
- Health promotion and partnership
 - Advocacy
 - Behavior change communication
 - Social mobilization
- Supply chain management
 - Acquisition of malaria control inputs: technical expertise, regulatory framework, technical specification, and quantification and quality control of inputs
 - Management of malaria control inputs: storage, management tools, logistical capacities, training, and monitoring
 - Distribution of malaria control inputs at different levels: procedures, logistical means, networking, partnership, and other.
- Surveillance/monitoring and evaluation
 - Planning
 - Monitoring/follow-up/supervision/review
 - Data quality assurance
 - Evaluations/studies and operational research

IV. KEY MALARIA DATA

Despite relatively high levels of ITN ownership and use and increasing IPTp coverage, malaria prevalence remains high in the years that nationally representative surveys have been conducted (Table 3). Also, although IPTp coverage is increasing, there is still a large missed opportunity as ANC4 coverage is 70 percent versus IPTp3 coverage of only 53 percent. As measured in these surveys, care seeking for fever for children under five years of age has remained relatively stable at ~60 percent and testing (finger/heel stick) is stable and quite low (~25 percent). It should be noted that mass ITN campaigns were conducted in 2017 and 2020, the same years that surveys were conducted.

EVOLUTION OF KEY SURVEY BASED MALARIA INDICATORS

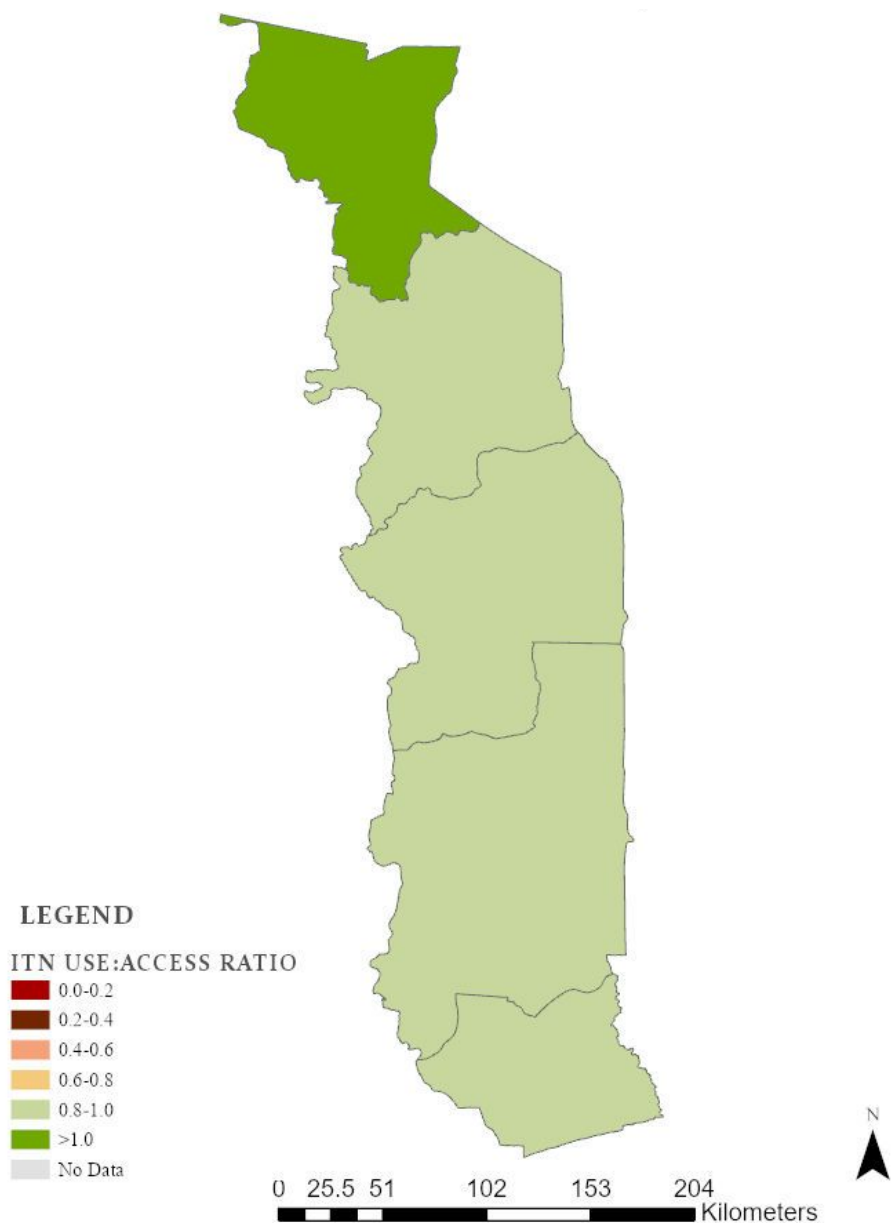
Table 3. Key Survey Indicators

Indicator	2013–14 DHS	2017 MIS	2017 MICS	2020 MIS ¹
% of households with at least one ITN	65%	85%	71%	91%
% of households with at least one ITN for every two people	33%	71%	43%	78%
% of population with access to an ITN	49%	82%	58%	87%
% of population that slept under an ITN the previous night	34%	63%	51%	60%
% of children under five years of age who slept under an ITN the previous night	43%	70%	61%	67%
% of pregnant women who slept under an ITN the previous night	40%	69%	57%	68%
% of children under the age of five with a fever in the last two weeks for whom advice or treatment was sought	59%	56%	54%	62%
% of children under the age of five with a fever in the last two weeks who had a finger or heel stick	24%	29%	27%	25%
% of children under the age of five receiving an ACT among those with a fever in the last two weeks who received any antimalarial drug	50%	76%	18%	59%
% of women who attended four ANC visits during their last pregnancy	57%	N/A	55%	70%
% of women who received three or more doses of IPTp during their last pregnancy in the last two years	19%	41%	37%	53%
Under five mortality rate per 1,000 live births	88	N/A	71	N/A
% of children under the age of five with parasitemia by microscopy	36%	28%	N/A	36%
% of children under the age of five with parasitemia by RDT	38%	44%	N/A	36%

¹ The 2020 MIS is not available online. It was conducted by the Togo National Institute of Statistics and Economics and Demographic Studies (*Institut national de la statistique et des études économiques et démographiques*, INSEED).
DHS: Demographic and Health Survey (DHS); MICS: Multiple Indicator Cluster Survey; MIS: Malaria Indicator Survey.

The ITN use-to-access ratio is above 0.8 in all regions and is greater than 1.0 in the northernmost region, Savanes (Figure 8). This means that the majority of the population uses a net when one is available. In Savanes, on average, more than two people use every ITN.

Figure 8. ITN Use-to-Access Ratio Map



Source: MICS 2017.

Table 4. Evolution of Key Malaria Indicators Reported through Routine Surveillance Systems

Community-level data are integrated into the broader HMIS, and these numbers are inclusive of both community- and health facility-level data.

Indicator	2018	2019	2020	2021	2022
# of all-cause patient consultations	5,058,379	5,403,990	4,796,412	5,015,229	5,521,168
# of suspect malaria cases ¹	3,120,401	3,650,654	2,908,748	3,091,060	3,536,879
# of patients receiving diagnostic test for malaria ²	3,009,800	3,531,375	2,646,559	2,956,606	3,456,206
Total # of malaria cases ³	2,002,877	2,406,091	1,876,164	1,863,905	2,224,558
# of confirmed cases ⁴	2,002,877	2,40,091	1,737,469	1,863,905	2,224,558
# of presumed cases ⁵	0	0	138,695	0	0
% of malaria cases confirmed ⁶	100%	100%	93%	100%	100%
Test positivity rate (TPR) ⁷	67%	68%	66%	63%	64%
Total # of malaria cases in children under the age of five ⁸	708,432	877,193	621,996	634,630	746,766
% of cases in children under the age of five ⁹	35%	36%	36%	34%	34%
Total # of severe cases ¹⁰	30,534	39,939	37,467	38,895	43,415
Total # of malaria deaths ¹¹	905	1,275	929	809	905
# of facilities reporting ¹²	11,952	13,325	13,455	14,596	14,432
% of data completeness ¹³	97%	93%	93%	96%	96%

¹ Number of patients presenting with signs or symptoms possibly due to malaria (fevers). ² RDT or microscopy, all ages, outpatient and inpatient. ³ Total reported malaria cases, all ages, outpatient and inpatient, confirmed and unconfirmed cases. ⁴ Diagnostically confirmed, all ages, outpatient and inpatient. ⁵ Clinical/presumed/unconfirmed, all ages, outpatient and inpatient. ⁶ Number of confirmed cases divided by total number of cases. ⁷ Confirmed cases divided by the number of patients receiving a diagnostic test for malaria (RDT or microscopy). ⁸ Outpatient and inpatient, confirmed and unconfirmed. ⁹ Total number of cases in children under the age of five divided by total number of cases. ¹⁰ Severe cases are cases hospitalized with malaria. ¹¹ All ages, outpatient, inpatient, confirmed and unconfirmed. ¹² Total number of health facilities reporting data into the HMIS/DHIS2 system that year. ¹³ Number of monthly reports from health facilities divided by the number of health facility reports expected (average for the calendar year).

Table 5. Disaggregated Community-Level Data

Indicator	2019	2020	2021	2022
# of patients receiving diagnostic test for malaria from a CHW	959,807	631,649	699,510	874,511
Total # of malaria cases reported by CHWs ¹	794,727	524,568	562,433	728 679
% of CHW reported cases (among total malaria cases) ²	33%	28%	30%	33%

¹ Includes all ages, confirmed and unconfirmed. ² Total number of malaria cases reported by CHWs divided by the total number of malaria cases in the previous table. CHW: community health worker.

V. Other Implementation Information

According to the NSP, antimalarial therapeutic efficacy studies are to be done every two years, following WHO guidance. Studies target six sentinel sites (HP Yendoubé, CHP Niamtougou, Polyclinique Tchaoudjo, HP Anié, CMS Providence Kouvé, and CMS de Cacaveli). The results from these studies are used to help the NMCP make decisions on antimalarial drug policies.

Table 6. Summary of Completed Therapeutic Efficacy Studies

Year	Site	Treatment Arm(s)	Efficacy (PCR-corrected adequate clinical and parasitological result) for Each Drug at Each Site
2021 ¹	Anié, Kouvé	AL, DP	Anié: AL: 98.7%, DP: 100% Kouvé: AL: 97.7%, DP: 98.8%

¹ *Efficacité Thérapeutique et Tolérance Clinique de deux Combinaisons Thérapeutiques à base de dérivées d'Artémisinine sur les sites sentinelles de Kouvé et d'Anié au Togo en 2021*, October 2022. AL: artemether-lumefantrine; DP: dihydroartemisinin-piperaquine.

VI. Key Policies

Table 7. Policies in Togo

National Strategic Plan: The NSP 2023–2026 is being validated (pdf available of previous NSP 2017–2022)
National SM&E Plan: <i>Plan du suivi et évaluation du programme national de lutte contre le paludisme 2017–2022</i>
National Digital Health Strategy: n/a
National Social Behavior Change/Communication Strategy: <i>Plan de communication du Plan Stratégique National de Lutte contre le Paludisme 2021–2023</i> (not available online). There is also an annex with a messages guide (<i>guide des messages</i>).
National Supply Chain Strategy/Master Plan: <i>Stratégie Nationale d'Optimisation de la Chaîne d'Approvisionnement des Produits de Santé au Togo (CAPS–TOGO) 2019–2022</i>
National Vector Control Strategy and/or Integrated Vector Management Plan: Plan Stratégique National de Gestion de la Résistance des Vecteurs aux Insecticides
Malaria Case Management Policy: <i>Directives Nationales de Traitement Antipaludique</i> (August 2016)

What is/are the first-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*?	AL
What is/are the second-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*?	Dihydro artémisinine pipéraquine (DHA-PPQ)
What is the first-line treatment for severe malaria?	Injectable artesunate (injectable artemether, second-line)
In pregnancy, what is the current first-line treatment for uncomplicated <i>P. falciparum</i> malaria in the <i>first trimester</i> ?	From the 2023–2026 draft NSP: “Current WHO guidelines for the treatment of uncomplicated malaria recommend ACTs in the first trimester of pregnancy.”
Given the WHO policy change to recommend AL as treatment for uncomplicated malaria in the first trimester, does the MOH plan to update the policy on treatment of MIP in the first trimester? And if so, what is the status of this policy change and implementation of the new policy? (please include any plans for training providers on the new policy)	This policy has been communicated to health workers via an official administrative letter but has not yet been fully integrated into NMCP guidance documents. Training needs are being taken into account in current planning.
In pregnancy, what is/are the first-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria in the <i>second and third trimesters</i> ?	AL
In pregnancy, what is the first-line treatment for severe malaria?	Injectable artesunate
Is prereferral treatment of severe disease recommended at peripheral health facilities? If so, with what drug(s)?	Yes, Injectable artesunate
Is prereferral treatment of severe disease with rectal artesunate recommended for community health workers?	No
Community Health Policy: <i>Plan Strategique National des Interventions à Base Communautaire (PSN IBC)</i> (2021–2025)	
What is the # of CHWs currently providing iCCM?	1,412 CHW in Savanes and Kara regions currently are actively providing iCCM. The current Global Fund grant (NFM3) has support to train 3,889 CHW in iCCM. The remaining CHW of the 7,500 total provide malaria community case management).
What is the country’s target for number of CHWs providing iCCM?	7,500
What percent of the country’s target is met?	19 percent
Does the country have a policy that enables the routine, regular payment of salaries/stipends for CHWs?	No, however there is work ongoing to establish a community health policy that would include specifications on compensation. Currently, the Global Fund NFM3 grant supports the payment of a small stipend via mobile money after validation of activity reports by the Togolese Red Cross.

Do CHWs have the authority to test and treat all ages for malaria?	Yes
Prevention of Malaria in Pregnancy Policy: <i>Prevention et controle du paludisme pendant la grossesse au Togo</i> (April 2021)	
At what gestational age is the first dose of IPTp-SP to be given to pregnant women according to the national guidelines for malaria and MCH?	13 weeks
Do the national ANC guidelines reflect the WHO 2016 recommendation of eight ANC scheduled contacts (plus one additional contact for early initiation of IPTp at 13–16 weeks)? If not, how many ANC contacts are recommended?	Yes
What is the status of training ANC providers on the WHO recommended eight or more contacts?	In progress
Have HMIS/DHIS2 and ANC registers been updated to include eight or more contacts?	Yes
Are ANC/IPTp data collected as single months where the January 2022 data represent the number of doses administered in January 2022, or cohort data, representing the cumulative data from pregnancies which began six months prior?	Single months
Is ANC/IPTp provided by facility staff conducting ANC outreach to communities?	Yes, health facility staff provide ANC and IPTp to pregnant women in villages more than 5 km from facilities. They also provide ANC reminders. All districts are covered but not all health facilities are included.
Can CHWs deliver IPTp and if so, which specific cadres and beginning with which dose? How many districts are targeted for c-IPTp implementation?	cIPTp is not formally recommended or implemented. However, CHWs can deliver IPTp starting with the second dose. The first dose must be administered at an ANC visit. Before cIPTp would be considered, a feasibility study is requested to identify districts in which to launch, in collaboration with other programs. This is not currently planned.

ANC: antenatal care; AL: Artemether-lumefantrine; CHW: community health worker; cIPTp: community-level intermittent preventive treatment for pregnant women; DHIS-2: District Health Information Management System 2; HMIS: health management information system; ICCM: integrated community case management; IPTp: intermittent preventive treatment for pregnant women; MCH: maternal and child health care; MIP: malaria in pregnancy; NMCP: National Malaria Control Program; SP: sulfadoxine-pyrimethamine; WHO: World Health Organization;

VII. PARTNER LANDSCAPE

Table 8. Partner Landscape

Partner	Key Technical Interventions	Geographic Coverage	Funding Amount or In-Kind Contribution	Time Frame
Global Fund	• Support for nationwide mass campaign in 2023 and in 2026 • Procurement of national needs for all malaria commodities • Training and supportive supervision in all regions	• National	GC7: Total: €64,085,190 Malaria: €47,363,613 HSS: €16,721,577	Current grant covers 2021 to 2023; GC7 covers 2024 to 2026
Government of Togo		• National	~\$3M in ITN campaign years (2023, 2026) ~\$500,000 in other years	Annually
Malaria Consortium via philanthropic funding	• Supports seasonal malaria chemoprevention implementation	• Seven districts in Savanes Region	\$888,000 per year	Annually since 2020
Against Malaria Foundation	• Procurement of ITNs for mass campaigns ○ ~4 million ITNs procured in 2023 ○ ~4 million ITNs procured in 2020 ○ ~2.4 million ITNs procured in 2017	• National	~\$10.35 million per campaign (2023 and 2026)	Every three years: 2017, 2020, 2023, 2026 (planned)
UNICEF	• Procurement of nonmalaria drugs for CHW • Procurement of SPAQ for seasonal malaria chemoprevention needs in one region	• Seven districts in Savanes Region	~\$210,000	Annually

AL: artemether-lumefantrine; CHW: community health worker; ITN: insecticide-treated nets; SPAQ: sulfadoxine-pyrimethamine + amodiaquine.