RÉPUBLIQUE TOGOLAISE

MINISTRY OF HEALTH AND HYGIENE

NATIONAL EYE HEALTH DEVELOPMENT PLAN (NEHDP) Phase1 : 2025-2027

NATIONAL EYE HEALTH PROGRAM

FINAL VALIDATION-SEPTEMBER 2025

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PREFACE

Eye health is today a major public health and human development issue. In Togo, visual impairments and avoidable blindness weigh heavily on people's quality of life, on national productivity, and on social inclusion. Aware of this impact, the Government has made of universal and equitable access to quality eye care a strategic priority, in full alignment with **the National Health Development Plan (NHDP 2023-2027)** and with the commitments made within the framework of the **Sustainable Development Goals** and **Universal Health Coverage (UHC).**

This **National Eye Health Development Plan (NEHDP 2025-2027)**, the first phase of a long-term agenda extending until 2032, reflects this political will. Built on a thorough analysis of the situation, it relies on recent achievements – notably the elimination of trachoma as a public health problem – while providing concrete responses to persistent challenges: a shortage of specialized human resources, regional disparities, outdated infrastructure, insufficient equipment, and funding still too dependent on households.

This first phase (2025-2027) aims to quickly improve the accessibility and quality of care, strengthen human and technical capacities, and produce reliable indicators to guide public decision-making. The second phase (2028-2032) will aim to consolidate and expand the gains, generalize international quality standards, integrate technological innovations (telemedicine, interoperable information systems), strengthen research, and diversify financing mechanisms.

Beyond health, this plan is a **lever for human and economic development**. By reducing the burden of avoidable visual impairments, it will help to increase the autonomy of populations, promote social inclusion, and improve national productivity.

I would like to commend the commitment of the technical teams of the National Eye Health Program, actors in the public and private sectors, civil society, communities, as well as technical and financial partners, whose support is crucial for the success of this plan. I encourage all stakeholders to take ownership of this strategic document and to unite their efforts to ensure its effective implementation.

It is together, with determination and solidarity, that we will succeed in building by 2032 an integrated, accessible, and sustainable eye care system, guaranteeing every Togolese the fundamental right to eye health.

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Minister of Health and public Hygiene

ACRONYMS AND ABREVIATIONS

CBM	: Christian Blind Mission
CHW (ASC)	: Community Health Worker
CPAEGM	: Central Procurement Agency for Essential Generic Medicines (CAMEG)
DHIS2	: District Health Information Software 2
DR	: Diabetic Retinopathy
ECSAT	: Eye Care Situation Analysis Tool
EPI	: Expanded Program on Immunization
FHS (FSS)	: Faculty of Health Sciences
GDP	: Gross Domestic Product
HDI (IDH)	: Human Development Index
HFTM	: Health Facility Training Manager
HPE	: Hospital Establishment Project
HR	: Human Resources
IEC	: Information, Education, Communication
IPEC	: Integrated People – centred Eye Care
MEL (SEA)	: Monitoring, Evaluation and Learning
NCDs	: Non-Communicable Diseases
NEHDP	: National Eye Health Development Plan
NEHP	: National Eye Health Program
NHDP	: National Health Development Plan
NHII (INAM)	: National Health Insurance Institute
NHP (PNS)	: National Health Policy
NGO	: Non Gouvernemental Organization
NSMA(ENAM)	: National School of Medical Assistants
NSSF (CNSS)	: National Social Security Fund
NTDs	: Neglected Tropical Diseases
OCDI	: Organization of Charity for Integral Development
RAAB	: Rapid Assessment of Avoidable Blindness
RHC (CHR)	: Regional Hospital Center
SAFE	: Surgery, Antibiotics, Facial cleanliness, Environmental improvements
SDGs	: Sustainable Development Goals
UHC	: Universal Health Coverage
UHI (AMU)	: Universal Health Insurance
UTH (CHU)	: University Teaching Hospital
WHO	: World Health Organization

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EXECUTIVE SUMMARY

Eye health is a major issue in Togo, where visual impairments and preventable blindness heavily impact the quality of life of the population and socio-economic development. The evaluation of the 2019-2023 Five-Year Eye Health Plan, extended into 2024, highlighted significant progress, notably the elimination of trachoma as a public health problem and the strengthening of certain human and material capacities. However, it also revealed persistent challenges: a lack of harmonized standards, insufficient and concentrated human resources, outdated infrastructure, limited equipment, and low digitalization.

Faced with these challenges, the National Eye Health Development Plan (NEHDP) proposes an ambitious and realistic roadmap, aligned with the NPHD 2023-2027 and the WHO resolution WHA73.4 on Integrated People-Centred Eye Care (IPEC). It is part of a long-term vision (horizon 2032) and will be implemented in two phases:

- Phase 1 (2025-2027): quickly improve accessibility and quality of care, strengthen human resources, modernize a targeted number of infrastructures, and produce key indicators for the evaluation of the NPHD.
- Phase 2 (2028-2032): consolidate and expand achievements, generalize international quality standards, modernize the technical platform, integrate innovations (telemedicine, interoperable information systems), strengthen research, and diversify funding.

The NEHDP stands on five components :

1. Strengthening human resources in eye health.
2. Development and modernization of infrastructure and equipment.
3. Prevention and control of priority eye diseases.
4. Governance and multisectoral coordination.
5. Research in eye health.

The total cost of Phase 1 is estimated at one billion six hundred and seven million six hundred thousand (1,607,600,000) CFA francs, financed by the State, technical and financial partners, the private sector, and communities. Implementation will rely on a clear institutional framework and a monitoring and evaluation system based on continuous learning, ensuring rapid adjustments and continuous performance improvement.

Overall, this plan is intended to be pragmatic in its actions, ambitious in its vision, and sustainable in its impacts. It represents a decisive lever for reducing avoidable blindness, improving eye health, and contributing to the objectives of Universal Health Coverage and Sustainable Development in Togo.

1 INTRODUCTION

Eye health is a major national issue in Togo, where visual impairment and avoidable blindness continue to heavily affect the quality of life of the population and socio-economic development. Ensuring equitable and sustainable access to quality eye care for every citizen has now become a national priority, aligned with the momentum of Universal Health Coverage (UHC) and the National Health Development Plan (NHDP) 2023–2027.

It is within this framework that the National Eye Health Development Plan (NEHDP) 2025–2027 has been developed as a true strategic roadmap aimed at organizing, modernizing, and strengthening the provision of eye care services throughout the territory of Togo. Built on an in-depth situational analysis, the plan highlights major achievements — including the elimination of trachoma as a public health problem — as well as persistent challenges: shortages and unequal distribution of specialized human resources, regional disparities in infrastructure, and still limited access to care in rural areas.

The National Eye Health Development Plan (NEHDP) 2025–2027 is clearly action-oriented. It aims to **prevent, detect**, and **treat** the major eye diseases, while also **rehabilitating** people living with visual impairment and strengthening human, technical, and institutional capacities. Inspired by the WHO Resolution WHA73.4 on Integrated People-Centred Eye Care (IPEC) and aligned with national development commitments, it promotes a multisectoral and participatory approach involving public stakeholders, the private sector, civil society, communities, and technical and financial partners.

Beyond health, this plan constitutes a major lever for human development. By reducing the burden of avoidable visual impairment, it will help improve autonomy, social inclusion, and the productivity of the population. Its success will rest on four pillars: strong political commitment, rigorous planning, sustainable financing, and continuous monitoring and evaluation inspired by the concept of a **learning health system**.

Ultimately, the NEHDP 2025–2027 represents a strategic and mobilizing tool: pragmatic in its priorities, ambitious in its vision, and transformative in its impacts, ensuring every Togolese citizen's fundamental right to eye health.

2 GENERAL CONTEXT

2.1 Geographical location

Togo is a West African country whose southern coastline borders the Gulf of Guinea, with an area of approximately 56,790 km². It extends about 600 km from south to north and presents significant geographical diversity, including coastal plains, plateaus, and mountainous areas, particularly in the Plateaux region and in the northeast.

This topographical diversity influences the organization of healthcare infrastructure and the spatial distribution of facilities, including laboratories, due to logistical challenges related to access to rural and mountainous areas[1].

2.2 Demographical context

In 2022, the population of Togo is estimated at 8,095,498 inhabitants, comprising 4,150,988 women (51.3%) and 3,944,510 men (48.7%), giving a sex ratio of 95 men per 100 women, with an intercensal growth rate of 2.30%. The population is characterized by a very young structure, with a median age close to 19 years and approximately 42% of people under 15 years old, while nearly 60% are under 25 years old[2]. The urbanization rate is about 44%, with the majority of the urban population concentrated around Lomé, the capital city. This situation creates major challenges in ensuring equitable access to healthcare services between urban and rural areas.

2.3 Administrative organization

Since 2019, Togo has been divided into six administrative regions: Maritime, Plateaux, Centrale, Kara, Savanes, and Grand Lomé. The latter, known as the Autonomous District of Greater Lomé (DAGL), includes the prefectures of Golfe and Agoè-Nyivé, which are further divided into thirteen urban communes[3]. The country is composed of 39 prefectures, which are themselves subdivided into 117 communes. The planning and implementation of public policies, particularly in the health sector, are organized in accordance with this territorial structure. The health system is decentralized, with responsibilities shared between national, regional, and local authorities. This arrangement allows health interventions to be adapted to the specific needs and realities of different regions and local communities.

2.4 Economical and social context

Togo is a developing economy where a large share of the population depends on predominantly informal agriculture. Economic activity has shown strong resilience, with real GDP growth averaging 6.1% between 2021 and 2023, before slowing to 5.3% in 2024, with a recovery expected to reach 5.8% by 2026[4]. However, social progress remains limited, as reflected by a Human Development Index (HDI) of 0.571 in 2023, placing the country among those with medium human development.

This relatively low HDI constrains public resources available for investment in healthcare infrastructure and human resources[5]. Public spending on health and education remains below African and international benchmarks, at approximately 6.8% and 14.2% of the national budget respectively, compared to target levels of 15% and 20%. Around 55% of households live below the monetary poverty line, with nearly 28% of the population surviving on less than one dollar

[1] NPHD 2023-2027
[2] INSEED, RGPH-5 (2022)
[3] Law N°2019-006 on decentralization
[4] World Bank : Report Togo Economic Update 2024
[5] PNUD, Human development report 2025

per day, further limiting access to healthcare and widening inequalities in service coverage. In addition, social indicators reveal major challenges in education, access to safe drinking water, and sanitation, all of which are key determinants of public health. These socio-economic factors significantly affect the overall health status of the Togolese population and highlight the need for coordinated multisectoral interventions.[6].

2.5 Health financing

Health financing in Togo remains a major challenge that the government is addressing through the implementation of the National Health Policy (2030 horizon), which is based on Universal Health Coverage (UHC). UHC aims to ensure equitable access to quality healthcare services without exposing populations to financial hardship. However, despite the establishment of mechanisms such as Universal Health Insurance (UHI), currently being rolled out through the National Social Security Fund (NSSF) and the National Health Insurance Institute (NHII), the share of out-of-pocket payments remains high (66% in 2023)[7]. This represents a significant barrier to accessing healthcare, particularly in rural areas.

To reduce these financial obstacles, the Togolese government, with support from technical and financial partners, partially or fully subsidizes diagnostic services, treatments, and follow-up care within several priority health programs. This is notably the case in the fight against malaria, sexually transmitted infections (STIs), HIV/AIDS, hepatitis, and tuberculosis, supported by Global Fund financing. In addition, targeted maternal and child health programs such as WEZOU and "School AMU" receive full subsidies from the state and development partners, ensuring free healthcare for these vulnerable groups. These initiatives strengthen the territorial coverage of health services and actively contribute to the gradual achievement of UHC objectives, while also improving the quality of care delivery, particularly in eye health services.

2.6 Administrative organization of the health system in Togo.

The health system is organized into three levels: central, regional, and peripheral. The Ministry of Health ensures national coordination and regulation, while regions and districts manage the implementation of healthcare services. This organization aims to achieve universal health coverage, although coordination and resources still need to be strengthened.

2.7 Organization of the healthcare system in Togo.

The healthcare system is structured into primary care levels (community health workers, peripheral care units, communal health centers, and district hospitals), secondary care levels (regional hospitals and specialized regional facilities), and tertiary care levels (university hospitals and specialized referral hospitals)[8]. This structure is supported by a dense health network with more than 2,150 health facilities, dominated by the private sector (42%), followed by the public sector (34.5%), and faith-based and non-governmental organizations.

[6] NPHD 2023-2025
[7] MHPH, Performance Report 2023
[8] NPHD 2023-2027

Ophthalmology services are mainly concentrated at the secondary and tertiary levels but show significant disparities in equipment and human resources. This situation limits equitable access and the quality of care. The private sector generally has better infrastructure than public facilities, including ophthalmology services in university hospitals.

2.8 Health status of the population

2.8.1 Maternal and child health

Despite recorded progress, maternal and infant morbidity and mortality remain a concern. Visual complications related to pregnancy, childbirth, or early childhood—such as neonatal ophthalmia, congenital cataract, uncorrected refractive errors, and congenital glaucoma—can lead to severe visual impairments, with long-lasting effects on children's development and social integration.

Recent data highlight the extent of these challenges. In 2023, the maternal mortality rate was 399 deaths per 100,000 live births, and the neonatal mortality rate was 24 deaths per 1,000 live births[9]. Antenatal care coverage reached 99.5% in 2023, thanks to the "Wézou" program, which guarantees free healthcare services. However, disparities persist, particularly in rural areas.[10].

To prevent visual impairments linked to maternal and child health, Togo is implementing several interventions. The Expanded Programme on Immunization (EPI) includes vaccination against rubella, a major cause of congenital cataract. Innovative strategies, such as the use of multi-dose measles-rubella vaccine vials, have been adopted to improve vaccination coverage. Vitamin A supplementation, which is essential for preventing childhood blindness caused by vitamin A deficiency, reaches approximately 90% of children aged 6 to 59 months.[11]

Despite these advances, challenges remain. Coverage of early eye examinations is still insufficient, particularly in maternity wards and peripheral health centers. It is essential to strengthen the training of healthcare workers, improve access to specialized care, and raise community awareness about the importance of eye health from an early age. By integrating eye health into maternal and child care pathways, Togo aims to reduce avoidable visual impairments and improve children's well-being, thereby contributing to the achievement of the Sustainable Development Goals.

2.8.2 Health of youth and adolescents

Young people aged 10 to 24 represent a significant share of the Togolese population and face major challenges in sexual and reproductive health. The rate of early pregnancies remains high, with approximately 17% of adolescent girls having a child before the age of 18, which contributes significantly to maternal mortality within this age group.[12]. The prevalence of HIV

[9] NPHD 2023-2027
[10] WHO, AFRO,2024 Antenatal visits improve maternal health outcomes in Togo
[11] Word Bank, 2022 Vitamin A supplementation coverage rate (% of children ages 6-59 months) - Sub-Saharan Africa
[12] Unesco, 2018

among young women remains a concern, particularly due to insufficient access to sexuality education and appropriate services. In addition, a significant proportion of young women experience physical and sexual violence, affecting both their physical and mental health. Furthermore, screen addiction, which is increasingly common among young people, leads to notable eye strain, sleep disorders, and other visual problems, thereby compromising their overall well-being and school performance. In response to these challenges, national strategies, supported by international partners, aim to strengthen prevention, education, and access to healthcare for this population group.

2.8.3 Health of elderly and older adults

Although representing a moderate share of the population, older adults are experiencing increasing health needs due to the gradual rise in life expectancy. They are particularly affected by non-communicable diseases such as hypertension, diabetes, and cardiovascular conditions. The healthcare system remains poorly adapted to the specific management of this age group, with limited resources for geriatric care and social support. Difficult socio-economic conditions, isolation, and restricted access to services further increase their vulnerability. Strengthening health services tailored to the needs of older adults is an emerging priority in national policies.

2.8.4 Communicable diseases

Communicable diseases remain a major challenge in Togo, particularly affecting children and pregnant women. Malaria is the leading cause of childhood morbidity and can sometimes cause malarial retinopathy in severe cases. The national prevalence of HIV in Togo is estimated at around 1.6–1.7% in 2023–2025[13], with frequent ocular complications such as cytomegalovirus (CMV) retinitis and uveitis. Tuberculosis, toxoplasmosis, and measles continue to cause visual sequelae, while other bacterial and viral infections indirectly worsen eye health.

To limit these impacts, Togo is implementing targeted interventions, including the distribution of insecticide-treated mosquito nets, early malaria treatment, ophthalmological follow-up for people living with HIV, vaccination campaigns against measles and yellow fever, and integrated tuberculosis care. Strengthening the skills of healthcare workers and integrating eye health into these programs help prevent severe visual impairment and reduce avoidable blindness, thereby improving the quality of life of at-risk populations.

2.8.5 Neglected tropical diseases (NTDs)

Neglected tropical diseases (NTDs) mainly affect rural and peri-urban populations in Togo and are responsible for various ocular conditions. These diseases include onchocerciasis, schistosomiasis, lymphatic filariasis, human African trypanosomiasis, Guinea worm disease, leprosy, scabies, yaws, as well as other less common conditions. Togo succeeded in eliminating trachoma as a public health problem in 2022, thanks to the implementation of the SAFE strategy, which includes Surgery, Antibiotics, Facial cleanliness, and Environmental

[13] CNLS, 2023

improvement—particularly access to clean water and sanitation. This achievement is part of a broader set of integrated interventions aimed at reducing avoidable blindness linked to NTDs. Despite this progress, continued efforts are needed to control the remaining NTDs and to prevent ocular complications in high-risk areas.

2.8.6 Non-communicable diseases and disabilities

Non-communicable diseases (NCDs)—including cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases—represent a growing challenge in Togo, affecting mortality, morbidity, and quality of life. The prevalence of hypertension among adults aged 18–69 is 27.4% (STEPS 2021), while diabetes prevalence is 4.9%, showing a strong increase since 2010. These conditions directly contribute to ocular complications such as hypertensive retinopathy, diabetic retinopathy, glaucoma, and worsening of cataracts, thereby increasing avoidable blindness. Visual impairment remains high, with blindness prevalence estimated between 3.6% and 4.9%, and 40.8% of visual impairment reported in several regions (RAAB/ARCE 2024).

To address these issues, Togo is implementing NCD screening and follow-up programs, awareness campaigns on nutrition, physical activity, and tobacco reduction, as well as integrated ophthalmic services for early detection and management of visual complications, including surgery and follow-up for at-risk patients. These interventions aim to prevent avoidable blindness and improve population quality of life.

2.9 Social and environmental determinants

In Togo, limited access to safe drinking water and sanitation remains a major challenge, particularly in rural areas where only 68.58% of the population has access to an improved water source within a 30-minute walk[14]. Persistent poverty and social inequalities worsen living conditions and access to healthcare, contributing to the prevalence of preventable conditions, including visual disorders.

Furthermore, the country's tropical climate, characterized by a long rainy season, promotes the proliferation of vectors responsible for infectious diseases such as malaria, schistosomiasis, and trachoma. Frequent flooding and environmental conditions favorable to mosquito breeding increase the risk of disease transmission, directly impacting eye health.

To address these challenges, Togo has launched initiatives aimed at improving access to safe water and sanitation, particularly in the Greater Lomé region, with the goal of reaching 86% population coverage. Hygiene and sanitation awareness programs are also being implemented to reduce health risks[15].

In response to climate-related risks, the country is strengthening vector control strategies, including the distribution of ivermectin to combat onchocerciasis and the implementation of dengue prevention measures, such as managing mosquito breeding sites. These actions aim to

[14] *WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene (2020)*
[15] Word Bank (2023), Togo: A New Operation to Boost Access to Water in Greater Lomé

reduce the impact of social and environmental determinants on eye health and improve population well-being.

2.10 Ongoing structural reforms in the health sector and eye health

2.10.1 Contracting of healthcare facilities

Since 2018, an innovative contracting model has been introduced to support the financial management of healthcare facilities in Togo. This system aims to promote efficient and responsible resource management, enabling partner hospitals to improve their financial sustainability. Through this economic approach, several facilities have been able to carry out renovation works as well as acquire medical equipment, including ophthalmic equipment, in order to improve the quality and performance of their care units and services.

This strengthening directly contributes to improving healthcare delivery and patient satisfaction. The contracting program is currently managed and supported by the International Organization for Hospital Management (OIGH), which provides technical and strategic assistance for the effective implementation of these reforms in the participating facilities.

2.10.2 Institution de l'élaboration des projets d'établissement hospitalier dans le secteur de la santé

Since November 2024, the Ministry of Health of Togo has initiated a major reform aimed at modernizing hospital planning through the adoption of the Hospital Establishment Project (HEP) approach[16]. This multi-year strategic framework applies to all hospital and non-hospital facilities within the Togolese health system.

The introduction of the HEP provides a structuring opportunity for healthcare facilities and reference laboratories to align their activities with clear and ambitious objectives, thereby promoting continuous improvement in the quality of services delivered to the beneficiary populations.

The strengthening of human resources, the improvement of infrastructure, and the supply of equipment and various inputs are fully integrated into this approach, being included in the six core projects of the HEP, namely:

- The medical project, which defines clinical orientations and priorities,
- The care project, focused on the quality and safety of patient management,
- The managerial project, dedicated to the organization and governance of healthcare facilities,
- The investment and maintenance project, aimed at modernizing equipment and infrastructure,

[16] Guide d'élaboration de Projet d'établissement hospitalier (PEH), MSHP (2024)

- The information system project, which supports digitalization and data management,
- The social project, focused on human relations, communication, and ethics.

3 ANALYSIS OF THE EYE HEALTH SITUATION IN TOGO

3.1 Overview of eye health in Togo

3.1.1 Regulatory framework

Regulatory framework

The regulatory framework for eye health in Togo is fully aligned with the overall orientations of the national health system. The National Health Policy (NHP) and the National Health Development Plan (PNDS 2023–2027) recognize eye health as a fundamental component of primary healthcare. This official recognition led, in 2023, to the Ministry of Health and Public Hygiene transforming, through a ministerial decree, the former national blindness control programme—previously focused mainly on blindness prevention—into a National Eye Health Programme (NEHP) with an expanded scope. Since then, the NEHP has been responsible for coordinating, planning, and monitoring eye health activities at the national level.

The national eye health strategy is based on the principles of the global "2030 In Sight" initiative of the IAPB. However, the country does not yet have a specific legislative framework dedicated to eye health (e.g., a law on blindness prevention or regulation of optical and ophthalmic professions). Standards and treatment protocols are partially formalized but require updating to incorporate new WHO guidelines on Integrated People-Centred Eye Care (IPEC).

There are also legal texts governing certain eye care professions (such as ophthalmologists), but intermediate professions (opticians, ophthalmic nurses) are not yet clearly regulated, which limits the optimal deployment of human resources in eye health. The optometry profession also remains to be formally regulated.

Eye health is integrated into the national strategy for the fight against neglected tropical diseases (NTDs), particularly for trachoma control, with national guidelines aligned with the SAFE approach (Surgery, Antibiotics, Facial cleanliness, Environmental improvement).

Finally, health insurance mechanisms (AMU) partially cover ophthalmic care, but reimbursement for optical devices such as corrective glasses remains limited.

3.1.2 Organization of eye health services

Eye care services are structured around a network of health facilities comprising district hospitals, regional hospital centers, and university hospital centers. The latter serve as national reference centers in ophthalmology. In total, there are about fifty care units equipped with a basic ophthalmic platform (consultation services, examination rooms, and sometimes equipped operating theatres). Periodic surgical missions, often supported by NGOs, help strengthen eye care delivery during cataract surgery campaigns.

Community eye health services remain limited, although some mobile screening initiatives are implemented in rural areas through mobile teams or community health workers trained to detect early eye conditions. The private sector, consisting of ophthalmology clinics and private practices, provides a significant share of specialized consultations and surgeries, especially in Lomé.

Finally, national and international NGOs such as CBM, Lumière Divine, HDI, Sightsavers, FHI 360, the Swiss and Togolese Red Cross, Planète Vision, and Sight.org support the availability of equipment, staff training, and low-cost surgical services. However, the lack of a unified coordination mechanism between the public sector, private sector, and NGOs sometimes leads to overlapping interventions and insufficiently harmonized planning.

3.1.3 Trends in eye health care

3.1.3.1 Screening and management of cataract

Cataract remains the leading cause of blindness in Togo. Screening activities are carried out by the NEHP in collaboration with NGOs through mobile outreach campaigns and mass surgical campaigns. Between 2019 and 2023, approximately 8,000 to 9,000 cataract surgeries were performed annually, with an intraocular lens implantation rate exceeding 80%. In 2022, the Armed Forces Health Service launched the "Zero Cataract" initiative, a large-scale national campaign aimed at providing free surgery for about 10,000 people per year suffering from cataract, thereby strengthening the fight against blindness across the country. However, the surgical coverage rate is still below national needs, estimated at around 2,000 surgeries per million inhabitants per year. Households often bear the financial burden, limiting access for poor and rural populations. The integration of cataract surgery into the health insurance system (AMU) is progressing but remains partial.

3.1.3.2 Management of refractive errors

Refractive errors are the leading cause of visual impairment. Services for prescribing and dispensing glasses are mainly available in urban areas and within the private sector.

The school screening program initiated by the NEHP in collaboration with partners has made it possible to screen an increasing number of students affected by astigmatism, hyperopia, and myopia, and to provide free glasses to several thousand children.

However, the private optician market is not sufficiently regulated and is characterized by high costs for the general public.

3.1.3.3 Trachoma control

Togo officially eliminated trachoma as a public health problem in May 2022, thanks to the SAFE strategy (CHANCE in French), integrated into the National Program for the Control of Neglected Tropical Diseases (NTDs). Interventions are, however, continuing through the NEHP and the NTD program to sustain these achievements, particularly at the community level (facial and environmental hygiene), in collaboration with village development committees and schools. The surgical component for trichiasis is declining, but continued monitoring is required to prevent a resurgence of cases.

3.1.3.4 Management of glaucoma

Glaucoma is the leading cause of irreversible blindness in Togo, but it remains underdiagnosed. Tonometer equipment is available in some regional and university hospitals. Diagnosis is often made late, at an advanced stage, due to the lack of early and systematic screening and the high cost of medical treatment. Surgical and laser treatment options remain limited.

3.1.3.5 Prevention of diabetic retinopathy

Diabetic retinopathy is progressing with the increase in diabetes within the population (estimated prevalence of around 4.6% in 2021). Ophthalmological screening is not systematically carried out in diabetic patients. This is due to non-compliance with diabetes management protocols and financial and geographical barriers to accessing eye care services for these patients. Occasional campaigns conducted with NGOs allow for case detection, but there is no sustainable national strategy for active screening. Laser treatment is only available in a few centers in Lomé.

3.1.3.6 Improving visual health and health education

Information, education, and communication (IEC) activities are carried out, often in the form of community outreach or school-based awareness campaigns. Educational programs focus on eye hygiene, protection against UV rays, self-medication, and the importance of regular medical check-ups. However, these activities are not systematic, and the general public remains insufficiently informed and aware.

3.1.3.7 Care for people with visual impairment and blindness

Low vision care remains very limited. A few specialized structures (such as the Saint Augustine Center in Sokodé or schools for the blind) provide functional visual rehabilitation support services, but these services remain insufficient. There is still no national rehabilitation program for people with visual impairment or blindness, nor coverage for assistive devices (such as magnifying devices or white canes).

3.1.4 Equity in access to eye health services

Access to eye health services remains marked by significant geographic, socio-economic, and gender disparities. Modern infrastructure, ophthalmologists, and equipment are mainly concentrated in the capital and regional administrative centers. Rural populations sometimes travel more than 50 to 100 km to access a simple eye examination, which constitutes a major barrier.

Women, older adults, and vulnerable populations are proportionally more affected by blindness and visual disorders, yet they face many obstacles in accessing care, including financial difficulties, lack of autonomy, and low awareness. The cost of consultations, surgical procedures, and eyeglasses remains a major constraint.

While children are frequently affected by eye problems, particularly refractive errors, a widespread belief persists that only children from wealthier families wear corrective glasses. Awareness campaigns are essential to challenge these misconceptions and enable disadvantaged

children to access the visual correction they need, as untreated visual disorders often compromise their schooling and development.

At the same time, early screening for congenital cataract and refractive errors should be strengthened by involving maternal and child health professionals in training and education programs focused on systematic screening at maternity level and regular child follow-up, with special attention to eye health. Furthermore, access to corrective lenses should be improved for vulnerable populations.

Free screening campaigns temporarily improve access but remain insufficient to sustainably reduce inequalities. The inclusion of ophthalmic care in universal health coverage (AMU) or community-based insurance schemes is still limited. In addition, services for people living with severe visual disabilities (assistive devices, specialized or adapted education) remain very insufficient.

3.1.5 Standards for eye health care

Standards and protocols for ophthalmological care in Togo exist only partially and are not updated or applied uniformly. The guidelines from the "2030 In Sight" initiative served as a basis for developing the first protocols, but many health facilities operate without updated standardized documents. Ophthalmologists often rely on their own practices or on international references.

Efforts have been made to harmonize cataract surgical techniques (phacoemulsification or SICS), but guidelines on sterilization, surgical hygiene, emergency eye care, and postoperative follow-up are not available in all centers. The establishment of a national eye care manual integrated into the minimum package of activities of health centers remains to be formalized.

Minimum accessibility standards (1 ophthalmologist per 250,000 inhabitants; 1 equipped operating room per 500,000 inhabitants) have not yet been met in several regions. WHO Resolution WHA73.4 on IPEC (2020), concerning the integration of eye care into universal health coverage, still needs to be translated into national regulations in order to improve harmonization and quality of care.

3.1.6 Eye health care workforce

The country has an insufficient number of specialized human resources in eye health. There are approximately 35 to 40 active ophthalmologists nationwide, more than half of whom are concentrated in Lomé. Some regions have only one or two ophthalmologists to cover the entire regional population. There are also higher-level ophthalmic technicians (TSO), master's degree holders in ophthalmology, and specialized nurses, but their deployment in districts is irregular. To date, there are only two optometrists in the public sector, who are responsible for the PNSO mobile optical outreach program. Opticians, orthoptists, and ophthalmic assistants are very few in number, often trained abroad or through occasional projects. Ophthalmologist training is mainly provided by the Faculty of Health Sciences (FSS). Training of intermediate cadres (TSO and Master's level) has recently resumed at the National School of Medical Auxiliaries (ENAM) and the School of Medical Assistants (EAM). Partners such as CBM and Sightsavers

contribute to human resource training through workshops and occasional scholarships. A school of optics and optometry has been established and is expected to begin training in 2025.

Work overload, particularly in rural areas, reduces the time available for community screening and health education activities. Staff motivation is weakened by difficult working conditions and limited career development prospects.

3.1.7 Quality assurance management systems for eye health care

Quality management mechanisms in ophthalmic services are still in their early stages in Togo. There is no specific national system dedicated to quality assurance in ophthalmology, although some elements are included within broader hospital quality standards. Performance audits, patient satisfaction surveys, and monitoring indicators (e.g. postoperative visual acuity, infection rates, cataract complications) are not systematically collected.

In some centers supported by NGOs, quality improvement approaches have been introduced, including postoperative cataract follow-up and documented sterilization protocols. However, these practices are not standardized nationwide. There is no specific certification system for ophthalmic services, nor a national quality control committee in this field. Supervision activities are part of the NEHP's mandate, but visits are occasional due to limited logistical resources.

3.1.8 Eye health care infrastructure

Eye care infrastructures are present in most regional hospitals (CHR) and university hospitals (CHU), but their distribution remains uneven. Ophthalmology consultation rooms exist in regional hospitals and in some district hospitals, but operating theatres equipped for cataract surgery are functional in only about 6 to 7 centers. Some districts do not have a dedicated eye care room or the minimum equipment needed for basic eye examinations.

Several public facilities require renovation, particularly regarding running water, backup electricity supply, waiting areas, and sterilization units. The expansion of mobile screening units is a significant effort, but they remain insufficient to cover the full needs of rural populations.

3.1.9 Equipment and maintenance for eye health care

The ophthalmic technical platform varies by facility, with better equipment in institutions supported by partner projects. Basic equipment (slit lamps, auto-refractors, ophthalmoscopes, tonometers) is available at the regional level but is often absent or out of service at district level. Preventive maintenance of equipment is a major issue: broken devices are not systematically repaired due to a lack of maintenance contracts or biomedical technicians trained in ophthalmology. Operating rooms equipped for phacoemulsification or Small Incision Cataract Surgery (SICS) are few in number, and the availability of functioning operating microscopes remains limited. Laser equipment, angiography, and retinal imaging devices are mainly concentrated in private centers in Lomé. The lack of appropriate portable instruments for rural areas hinders mobile outreach activities and community-based screening.

3.1.10 Supply chain management of eye health products

The supply chain for ophthalmic medicines and consumables is mainly managed by the Central Medical Procurement Agency (CAMEG-Togo) for the public sector. However, several specific products (anti-glaucoma eye drops, viscoelastic substances, intraocular lenses, surgical instruments) are not always included on the national list of essential medicines. This leads to frequent stock-outs or forces patients to obtain these products from the private sector at high cost. Occasional donations of consumables by NGOs help ease critical shortages, particularly during cataract surgery campaigns, but this reliance on partners weakens the sustainability of the system. There is no standardized system for forecasting the needs of ophthalmic products, nor a specific mechanism for quality control of consumables.

3.1.11 Ophthalmic health care data management system

Data on eye health is collected through the tools of the National Health Information System (SNIS), but specific sections remain limited. Eye health indicators (number of ophthalmology consultations, cataract surgeries performed, trachoma rates, glaucoma cases, etc.) are not systematically disaggregated or documented across all districts. Some health facilities record data in local Excel spreadsheets, but there is no regular transmission to the central level. The National Eye Health Programme (PNSO) compiles data during campaigns or through quarterly reports, but the analysis remains insufficient to guide strategic decision-making. The integration of specific eye health modules into DHIS2 is under consideration but is not yet operational nationwide.

3.1.12 Research and development

Research in eye health remains limited and is mainly driven by a small number of academic ophthalmologists or joint projects with foreign institutions. Publications on cataract, glaucoma, diabetic retinopathy, refractive errors, onchocerciasis, and trachoma exist but remain sporadic. There is no national operational research programme in ophthalmology. Technological innovations, such as tele-ophthalmology screening or the use of connected portable devices, have not yet been developed. There is potential through the University of Lomé and partnerships with francophone scientific societies to establish a framework for research and the production of context-specific evidence adapted to the Togolese setting.

3.1.13 Public–private partnerships

Collaboration between the public sector and the private sector (private clinics, medical practices, NGOs, and international missions) is a key pillar of the eye health system in Togo. Many cataract surgery interventions and mobile outreach teams have been made possible thanks to NGOs and international institutions such as CBM, the World Bank (BID), Sightsavers, Light for the World, AIMES Afrique, Al-Basar International Foundation, and UNDP, as well as certain faith-based clinics such as COJP2, CHAO GLEI, and BETHESDA. However, this partnership is not formalized through harmonized national agreements nor governed by a clear partnership policy. There is a risk of fragmented interventions and inequalities, especially when the private sector sets fees that are unaffordable for the poorest populations. Establishing a regulatory

framework with standardized costs and clearly defined roles for each stakeholder would be necessary.

3.1.14 Financing of eye health

The financing of ophthalmic services relies mainly on out-of-pocket payments by households, with limited use of social protection mechanisms. The national budget allocated directly to eye health is marginal and is often included indirectly within maternal and child health programmes or Neglected Tropical Diseases (NTDs) initiatives. NGOs cover a significant share of costs related to surgical campaigns, equipment, and staff training. The Universal Health Insurance scheme (AMU) covers some basic ophthalmic services, but cataract surgery and the purchase of glasses are not yet fully included. Community-based health mutuals provide very limited coverage for these services. This heavy reliance on direct payments exposes vulnerable populations to a high risk of avoiding care or experiencing financial hardship. Sustainable financing for eye health remains a major challenge, requiring increased public funding, stronger integration into Universal Health Coverage (UHC), and sustained advocacy with technical and financial partners.

3.2 Main challenges of eye health in Togo

Eye health in Togo continues to face numerous challenges despite progress made in recent years. The main causes of visual impairment and blindness remain untreated cataract, uncorrected refractive errors, glaucoma, and diabetic retinopathy. Although trachoma was officially eliminated as a public health problem in 2022, post-elimination surveillance remains essential.

Eye health services are unevenly distributed, with a strong concentration of infrastructure and personnel in Lomé and regional capitals, leaving large rural areas poorly covered. The number of ophthalmologists is insufficient, estimated at less than 1 per 250,000 inhabitants, below WHO standards. Intermediate specialties (opticians, low vision technicians, glaucoma specialists, retinal specialists, eyelid specialists, etc.) are scarce and insufficiently regulated, limiting access to quality care at scale.

Financial accessibility is a major barrier: most care and equipment (cataract surgery, corrective glasses, anti-glaucoma eye drops) are paid directly by households, exposing poor populations to the risk of forgoing care. Health insurance systems only partially cover ophthalmic interventions, and community-based mutual health schemes do not yet include these services.

In addition, the technical equipment of health facilities is often insufficient or outdated. Maintenance and repair are rarely ensured, leading to prolonged breakdowns that disrupt continuity of care. The supply of specialized medicines and consumables is irregular due to limited availability in the central procurement system and dependence on NGO donations.

Finally, the national health information system collects little specific ophthalmology data, making it difficult to monitor performance indicators. The lack of structured national research on eye health also limits the production of evidence needed to guide public policy.

3.3 Future perspectives for eye health in Togo

Building on the validated elimination of trachoma, increasing support from partners, and the progressive integration of eye care into Universal Health Coverage (UHC), Togo aims to align its actions with the international momentum driven by WHO Resolution WHA73.4 and the EB146.R8 report on **Integrated People-Centered Eye Care (IPEC).**

The upcoming 2025–2027 National Eye Health Development Plan will take these guidelines into account, with the goal of strengthening the integration of eye care into UHC, improving human resources, and promoting innovative financing mechanisms to ensure equitable and sustainable access to care.

The development of telemedicine and mobile screening tools could significantly expand coverage, particularly in rural areas. In addition, the growing public–private partnership dynamic, although requiring better regulation, offers opportunities to expand service delivery.

The introduction of additional eye health tracer indicators into DHIS2 and the establishment of robust monitoring and evaluation systems will support better planning and decision-making. Finally, academic potential and international cooperation provide strong opportunities to develop national research, training, and capacity-building in ophthalmology and related health professions.

3.4 SWOT analysis of eye health in Togo

Togo has a structured National Eye Health Programme, supported by strong political commitment and active partners, with services available in all regions and within university hospitals (CHUs). Trachoma has been eliminated as a public health problem.

However, specialized human resources are unevenly distributed, cataract surgical coverage remains insufficient, and access to refraction and low vision services is limited. Equipment is often outdated, and financing relies heavily on out-of-pocket payments by households.

The sector benefits from major opportunities, including integration into Universal Health Coverage (UHC), the development of the private sector, technological innovations (telemedicine, portable imaging), and academic partnerships.

Threats include the rising burden of chronic eye diseases, urban–rural inequalities, post-trachoma stagnation, and dependence on external funding in the context of budgetary constraints.

Table 1: summary SWOT table of eye health in Togo

STRENGTHS	WEAKNESSES
• Existence of a structured National Eye Health Programme • Political commitment with the integration of eye health into the National Health Development Plan (PNDS) • Elimination of trachoma as a public health problem • Involvement of the Armed Forces Health Service in the fight against blindness through the "Zero Cataract" campaign • Presence of national and international NGOs (Planet Vision, Divine Light, Sight.org, Association Islam et Jeunes, etc.) • Technical and financial support from active partners (CBM, Islamic Development Bank, Sightsavers, CRS, IAPB, etc.) • Availability of ophthalmic services in every region, in university hospitals (CHUs), and in some districts • Celebration of World Sight Day	• Unequal and insufficient distribution of specialized human resources • Absence of certain human resource profiles (opticians, optometrists) in the public sector • Low cataract surgical coverage compared to needs (cataract surgery rate is 999 per million inhabitants in 2024) • Limited access to refraction and low vision services • High out-of-pocket payments by households despite Universal Health Coverage (UHC) • Weak and poorly disaggregated data collection systems • Equipment often outdated and poorly maintained • Inadequate training in some areas of eye health • Increasing prevalence of chronic diseases (diabetes, glaucoma) • Risk of stagnation of progress after trachoma elimination
OPPORTUNITIES	THREATS

• Alignment with the WHO IPEC (Integrated People-Centered Eye Care) resolution, strengthening a global and strategic framework for eye health • Progressive integration into Universal Health Coverage (UHC), improving financial protection and access to services • Development of the private sector and growing interest in eye health services • Technological advances such as telemedicine and portable digital imaging, expanding access and screening capacity • Growing academic research dynamics and opportunities for strengthened university partnerships • Project to strengthen regional ophthalmic structures, CHU SO, and CMS Baguida (Islamic Development Bank funding) • Operationalization of the optician–optometry training program for the 2025–2026 academic year • Social Structure Fund project (CBM and BMZ), supporting the development of social and health infrastructure	• Insufficient public funding in a context of ongoing budget constraints • Dependence on NGOs, with a risk of declining external financial support • Security risks in the sub-region, which may disrupt health interventions, partnerships, and service delivery

4 PRIORITIES FOR EYE HEALTH (2025–2027)

4.1 Foundations of the Plan (2025–2027)

Foundation of the Plan

The National Eye Health Development Plan (NEHDP) 2025–2027 is based on the evaluation of the 2019–2023 five-year eye health plan, extended into 2024, which made it possible to identify achievements, gaps, and priority needs. It is aligned with national commitments, including the National Health Development Plan (NHDP 2023–2027) and the Universal Health Coverage (UHC) strategy, as well as international frameworks and guidelines such as the WHO Integrated People-Centered Eye Care (IPEC) approach and Sustainable Development Goal 3.8.

The foundation of the plan is to ensure that every Togolese citizen has equitable access to quality eye health services that are integrated into the health system and financially accessible.

4.2 Alignment of the Plan with the National Health Strategy

The NEHDP 2025–2027 is aligned with the NHDP 2023–2027, to which it directly contributes by supporting the achievement of expected outcome 3.5: "the capacity for managing other diseases and health conditions (eye health and physical disability) is strengthened," under Strategic Axis 3, "disease control and management of social and environmental determinants." It also contributes to Togo's commitments to the Sustainable Development Goals (SDGs), particularly SDG 3 ("Ensure healthy lives and promote well-being for all at all ages") and SDG 1 ("No poverty"), through the reduction of the socio-economic impact of blindness.

4.3 Challenges of eye health in Togo

The main challenges identified for the 2025–2027 period include:

- Reducing the burden of untreated cataract and improving access to quality surgical care
- Expanding the availability of refraction services and optical correction
- Ensuring effective post-elimination surveillance of trachoma
- Improving screening and management of glaucoma and diabetic retinopathy
- Developing low vision care services and functional rehabilitation
- Improving the equitable distribution of eye health personnel
- Strengthening the skills and competencies of eye health staff
- Ensuring sustainable financing and reducing reliance on out-of-pocket payments
- Modernizing equipment and strengthening maintenance systems
- Improving data collection, analysis, and use for decision-making

4.4 Objectives of the Plan

4.4.1 General objective

To contribute to the reduction of the burden of blindness and visual impairment and to support people living with visual disabilities in Togo by 2027, through universal, equitable, and sustainable access to quality eye care services integrated into the national health system.

4.4.2 Specific Objectives

1. Increase the coverage and quality of cataract surgery through improved geographical and financial accessibility.
2. Strengthen screening and correction of refractive errors, particularly in school-aged populations.
3. Consolidate the gains from trachoma elimination and prevent its re-emergence.
4. Develop integrated screening and management programmes for glaucoma and diabetic retinopathy.
5. Establish low vision and functional rehabilitation units for people with visual disabilities.

6. Strengthen human resource capacity in both quantity and quality.
7. Improve the distribution of eye health human resources according to levels of care.
8. Ensure regular and sustainable supply of essential eye health products.
9. Improve sustainable financing of eye health by integrating services into social protection mechanisms and Universal Health Coverage (UHC).
10. Develop a monitoring, evaluation, and learning system and promote operational research in eye health.

5 NATIONAL EYE HEALTH DEVELOPMENT PLAN (NEHDP) 2025–2027 – ACTION FRAMEWORK

The National Eye Health Development Plan (NEHDP) 2025–2027 defines the strategic actions required to strengthen eye health in Togo. It is structured around **five priorities**, each aimed at generating significant and sustainable impacts on the population. These priorities are translated into **five outcomes** to be achieved by 2032, supported by a total of **21 transformational results** covering the strengthening of human resources, the development of infrastructure and equipment, the prevention and management of eye diseases, the improvement of the institutional and governance framework, as well as the development of applied research.

This action framework therefore provides a structured roadmap to ensure equitable access to quality eye care services, strengthen national capacities, and guide policies and interventions based on evidence.

5.1 Priority 1 : Development, deployment, and strengthening of human resources for eye health

Outcome 1: From January 1, 2025 to December 31, 2032, Togo has a sufficient number of qualified human resources in eye health, equitably distributed and equipped with up-to-date competencies to meet national needs.

Expected Result 1.1: The technical and professional capacities of human resources in eye health are developed and strengthened.	*Priority Activities :* 1. Organize annual training and capacity-building sessions for Ophthalmic Senior Technicians (TSOs), optician-optometrists, dispensing opticians, community health workers, and teachers.. 2. Establish a national certification programme for the development of competencies in cataract surgery, surgical instrumentation, and preoperative and postoperative care management. 3. Create a regular training evaluation and monitoring mechanism to ensure the continuous upgrading of staff competencies.
Expected Result 1.2: National eye health training institutions are strengthened.	*Priority activities :* 4. Strengthen the ophthalmology residency programme (DES) in Lomé through the establishment of a WetLab and the provision of scholarships. 5. Develop partnerships with international universities for specialized training programms.
Expected Result 1.3: The availability and equitable distribution of eye health personnel are improved.	*Priority activities :* 1. Establish an incentive mechanism to encourage the deployment and installation of professionals in underserved areas of the country. 2. Introduce a national system for monitoring careers and continuing professional development.
Expected Result 1.4: The attractiveness and retention of eye health professionals are strengthened.	*Priority activities :* 1. Develop an attractive and progressive career framework, including opportunities for specialization. 2. Establish a certified continuing education system to facilitate access to specialization and advanced technical training.

5.2 Priority 2: Development and Strengthening of Infrastructure, Equipment, and Health Products

Outcome 2: From January 1, 2025 to December 31, 2032, all regions have modern infrastructure and functional ophthalmic equipment, ensuring equitable, continuous, and quality access to eye care services.

Expected Result 2.1: The availability of specialized eye health infrastructure is increased.	*Priority activities :* 1. Plan and implement the construction of new Eye Care Units (ECUs) and Optical Units (OUs) in priority underserved areas.
Expected Result 2.2: Existing infrastructure is rehabilitated and equipment is upgraded.	*Priority Activities* 1. Conduct annual rehabilitation, renovation, and equipment upgrading of existing infrastructure, including quality monitoring of works.
Expected Result 2.3: Equipment is made available and kept in good working condition.	*Priority Activities* 1. Strengthen the skills of biomedical technicians in the maintenance of ophthalmic and optical equipment. 2. Reinforce regional maintenance services to ensure timely repair and technical support. 3. Equip the National Eye Health Program (NEHP) and ophthalmology services with a computerized equipment monitoring system integrated with DHIS2.
Expected Result 2.4: The availability of consumables is ensured.	*Priority activities* 1. Establish a centralized procurement mechanism for essential consumables, including intraocular lenses, surgical kits, glasses and frames, and low vision assistive devices. 2. Implement an integrated logistics monitoring system to improve tracking, forecasting, and stock management of ophthalmic consumables. 3. Strengthen partnerships with the private sector to support the importation, storage, and distribution of eye health consumables.

5.3 Priority 3: Prevention and Control of Priority Eye Diseases

Outcome 3: From January 1, 2025 to December 31, 2032, the prevalence and incidence of major preventable eye diseases are reduced through accessible and quality preventive, diagnostic, and curative interventions, as well as support for people living with visual disabilities.

Expected Result 3.1: The population adopts behaviours that promote eye health.	*Priority Activities* 1. Organize annual multi-channel awareness campaigns (media, community-based, and school-based) targeting major priority eye diseases. 2. Train health workers and community health volunteers in awareness-raising techniques and early detection of eye diseases. 3. Integrate eye health into school health promotion programmes.
Expected Result 3.2: Childhood eye diseases are better managed.	*Priority Activities* 1. Organize early screening of visual disorders in children. 2. Advocate for the integration of eye examinations for children into the Expanded Programme on Immunization (EPI/PEV). 3. Strengthen regional ophthalmic surgical services for the management of paediatric eye conditions. 4. Reinforce integrated management of paediatric ocular cancers (e.g., retinoblastoma). 5. Raise awareness among parents, teachers, and communities on the importance of early detection and treatment of childhood visual disorders.
Expected Result 3.3: Cataract is effectively managed.	*Priority Activities* 1. Harmonize the costs of cataract surgery interventions. 2. Advocate for reduced-cost procurement of ophthalmic surgical consumables. 3. Subsidize the cost of surgery, including surgical kits and consumables. 4. Increase the number of cataract surgeries performed in fixed health facilities. 5. Organize outreach surgical campaigns in hard-to-reach areas.
Expected Result 3.4: Refractive errors are appropriately managed.	*Priority Activities* 1. Strengthen annual school-based screening for refractive errors in children. 2. Provide free spectacles to children diagnosed with refractive errors. 3. Provide low-cost glasses to the general population through public optical units. 4. Screen and manage refractive errors in persons living with albinism.

Expected Result 3.5: Glaucoma is diagnosed early and managed effectively.	*Priority Activities* 1. Raise awareness among medical and paramedical staff on glaucoma. 2. Establish a telemedicine system for expert consultation and clinical support. 3. Implement a national glaucoma screening programme targeting high-risk populations.
Expected Result 3.6: Diabetic retinopathy is integrated into the management of chronic diseases.	*Priority Activities* 1. Sensitize medical and paramedical staff on systematic screening for diabetic retinopathy in diabetic patients. 2. Implement a national screening programme for diabetic retinopathy among at-risk populations.
Expected Result 3.7: Support for people with visual disabilities is strengthened.	*Priority Activities* 1. Strengthen the capacity of specialized visual rehabilitation centres. 2. Train primary healthcare workers to detect severe visual impairment early, refer patients appropriately, and assess the specific needs of low-vision and blind persons. 3. Organize awareness campaigns on the challenges faced by visually impaired persons and promote their social inclusion (education, employment, leisure). 4. Strengthen collaboration between the NEHP, visual rehabilitation centres, and the Ministry of Education in the care of visually impaired or blind students.

5.4 Expected Result 4.1: Strengthenning of the governance and the leadership of the eye health programm

Outcome 4: From January 1, 2025 to December 31, 2032, eye health in Togo benefits from a strong institutional framework, effective governance, and efficient multisectoral coordination.	
Expected Result 4.1: The policy and regulatory framework for eye health is strengthened.	*Priority Activities* 1. Develop and disseminate harmonized protocols for diagnosis and management of eye diseases. 2. Integrate eye health into national public health strategies. 3. Contribute to the revision of training curricula for different eye health professional categories.

Expected Result 4.2: Coordination and governance are improved.	*Priority Activities* 1. Strengthen regional coordination committees. 2. Build the planning and management capacity of NEHP managers. 3. Establish a multisectoral coordination mechanism involving education, social protection, NGOs, and the private sector. 4. Create a multi-stakeholder monitoring and learning committee.
Expected Result 4.3: Resources and logistics are mobilized and optimized.	*Priority Activities* 1. Equip the NEHP with an operational logistics fleet (vehicles, motorcycles, mobile clinics) to support implementation activities. 2. Ensure maintenance and insurance of vehicles and equipment.
Expected Result 4.4: Monitoring and evaluation, learning, and information management are strengthened.	*Priority Activities* 1. Maintain an updated assessment of eye health infrastructure needs. 2. Equip key stakeholders with modern IT tools. 3. Integrate eye health tracer indicators into DHIS2 and train users. 4. Conduct a situational analysis of eye health services using ECSAT. 5. Develop and implement an annual monitoring, evaluation, and learning plan. 6. Conduct a final evaluation of NEHDP Phase 1. 7. Introduce an interactive national dashboard within DHIS2 for real-time monitoring of key performance indicators of the plan.

5.5 Priority 5 (Cross-cutting): Eye Health Research

Outcome 5: From January 1, 2025 to December 31, 2032, research findings effectively inform and guide eye health policies and interventions.

Expected Result 5.1: A national operational research programme in eye health is in place and functional.	*Priority Activities* 1. Develop and validate the national eye health research agenda. 2. Define research priorities aligned with national needs (cataract, glaucoma, diabetic retinopathy, refractive errors, visual disability, and access to care). 3. Establish structured partnerships with academic and research institutions. 4. Set up a national scientific committee for eye health. 5. Mobilize and allocate dedicated financial resources for research activities. 6. Ensure dissemination and valorization of research findings. 7. Strengthen the capacity of national researchers through training in methodology, project management, scientific writing, and statistical analysis.

5.6 Assumptions for effective implementation of the Plan

The effectiveness of the implementation of the National Eye Health Development Plan (NEHDP) 2025–2027 is based on a set of key assumptions. First, it is assumed that the political commitment of the Government of Togo towards Universal Health Coverage (UHC) will be maintained, allowing the progressive integration of eye care into essential health service packages. Second, the availability and mobilization of adequate financial resources, both domestic and international, are essential conditions for the implementation of planned activities.

Furthermore, it is assumed that multisectoral coordination among stakeholders—including the Ministry of Health, technical and financial partners, NGOs, the private sector, and local authorities—will be strengthened and effective. The success of the plan also depends on the assumption that the socio-economic and security context will remain relatively stable, allowing uninterrupted implementation of interventions across all regions. Finally, implementation assumes strong community engagement, with active participation of associations of people living with visual impairment and increased ownership of interventions by district health authorities.

5.7 Theory of Change

The NEHDP 2025–2032, with its Phase 1 (2025–2027), is based on a clear vision: to significantly reduce the burden of avoidable visual impairment in Togo through the establishment of an integrated, accessible, equitable, and high-quality eye health system.

The central assumption is that targeted improvements in human resources, infrastructure, prevention and care programmes, governance, and research will collectively lead to a sustainable impact on the visual health of the population.

To achieve this impact, the plan relies on several long-term outcomes: having a sufficient number of skilled personnel, modern and well-distributed infrastructure, a well-informed population adopting healthy practices, a strong institutional framework, and research that generates evidence-based data.

These outcomes can only be achieved if intermediate results are met, such as strengthening human capacity through training and supervision, continuous construction and equipping of facilities, implementation of sustained prevention campaigns, formalization of coordination mechanisms and resource mobilization, as well as the development of a national applied research programme.

At the core of this dynamic, the involvement of institutional actors, health professionals, technical and financial partners, and communities is crucial. Their engagement promotes the adoption of best practices, the sustainability of interventions, and continuous adaptation to local realities.

The expected change is therefore grounded in a strengthened system capable of ensuring the prevention, screening, treatment, and care of people with visual disorders, within a framework of territorial and social equity.

Finally, ongoing monitoring, evaluation, and learning will inform strategic adjustments, ensuring the effectiveness of the NEHDP and the progressive achievement of its objectives.

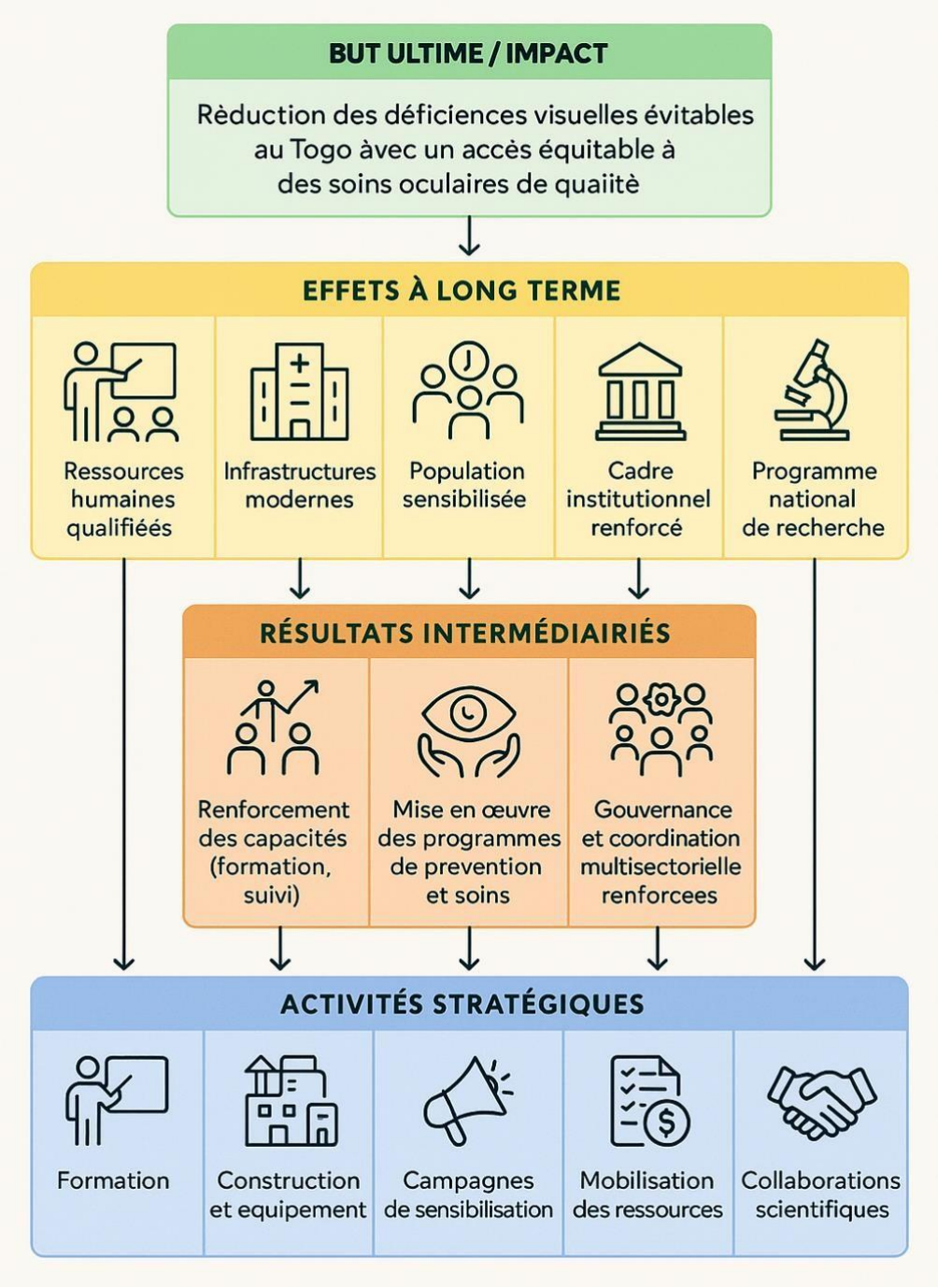

Figure 1 : Diagram of the Theory of Change of the PNDSO

6 FINANCING AND IMPLEMENTATION FRAMEWORK OF THE PLAN

6.1 Budget of the plan

The total estimated budget of the National Eye Health Development Plan (NEHDP) 2025–2027 amounts to **One billion six hundred and seven million six hundred thousand (1,607,600,000) CFA francs.** This amount covers all the strategic interventions defined within the framework of the plan, with particular emphasis on key areas of eye health, the training of

sector stakeholders, the strengthening of infrastructure, the prevention of priority eye diseases, as well as strategic communication to ensure broad awareness and mobilization.

6.1.1 Cost per component

The expenditures are broken down by components:

- Component 1: Strengthening human resources in eye health.
- Component 2: Development and modernization of infrastructure and equipment.
- Component 3: Prevention and control of priority eye diseases.
- Component 4: Multisectoral coordination and governance.
- Component 5: Eye health research.

The communication plan budget is also included in the overall budget estimate of the NEHDP 2025–2027.

Table 2 : Cost per component

Component	Total Cost over 3 years (FCFA)
Component 1: Strengthening Human Resources	45,600,000
Component 2: Infrastructure and Equipment	255,000,000
Component 3: Prevention and Control of Eye Diseases	990,000,000
Component 4: Multisectoral Coordination and Governance	74,000,000
Component 5: Eye Health Research	60,000,000
Communication plan	*183,000,000*
Total estimated budget NEHDP 2025–2027	**1,607,600,000**

6.1.2 Cost per component and per intervention

The estimated budget is broken down by cost per intervention in order to facilitate the monitoring of resource mobilization, the implementation of the plan, and the impact evaluation of each of these interventions.

Table 3 : Estimated budget cost per component and per intervention

Component	Intervention	Total Cost over 3 years (FCFA)
Component 1: Strengthening Human Resources	Training of HFTM, CHWs (ASC), OCT, opticians, and teachers	45,600,000
Component 2: Infrastructure and Equipment	Construction of OCU (Ophthalmic Care Units)	180,000,000
Component 2: Infrastructure and Equipment	Upgrading ophthalmological equipment	75,000,000
Component 3: Prevention and Control of Eye Diseases	Awareness campaigns	90,000,000

Component 3: Prevention and Control of Eye Diseases	Surgical kits for cataract surgery	750,000,000
Component 3: Prevention and Control of Eye Diseases	Provision of glasses for children	150,000,000
Component 4: Multisectoral Coordination and Governance	Multisectoral coordination meetings	24,000,000
Component 4: Multisectoral Coordination and Governance	DHIS2 IT tools for management and monitoring	50,000,000
Component 5: Eye Health Research	Applied research projects	30,000,000
Component 5: Eye Health Research	Training of researchers	30,000,000
Communication plan	Multichannel communication and awareness campaigns	183,000,000
Total estimated budget NEHDP 2025–2027		**1,607,600,000**

6.1.3 Cost per challenge

The budget is also broken down according to the major identified challenges, namely: reducing access inequalities, modernizing infrastructure and equipment, ensuring the availability of eye health medicines and products, strengthening the health information system, and strategic communication.

Table 4 : Estimated budget cost per challenge

Challenge	Intervention	Total cost over 3 years (FCFA)
Challenge 1: Reduction of access inequalities	Construction of OCUs, staff deployment, staff training	225,600,000
Challenge 2: Modernization of infrastructure and equipment	Upgrading of equipment	225,000,000
Challenge 3: Availability of eye health medicines and products	Surgical kits for cataract, glasses for children	900,000,000
Challenge 4: Strengthening the health information system	DHIS2 tools, development of dynamic dashboards	50,000,000
Challenge 5: Multisectoral coordination	Multisectoral coordination meetings	24,000,000
Challenge 6: Strategic communication	Multichannel communication, production of materials, events	183,000,000
Total		**1,607,600,000**

6.1.4 Cost by nature of expenditure

The estimated budget is broken down by type of expenditure (equipment investment, operational costs, human resources, communication, supervision, and monitoring & evaluation) in order to ensure optimal traceability and transparency.

Table 5 : Estimated budget cost per nature of expenditure

Type of expenditure	Number of interventions over 3 years	Total Cost (FCFA)
Infrastructure and equipment investment	6 OU/OCU units + 5 interconnected systems	281,000,000
Operations and supervision	12 meetings + 15,000 glasses + 6 integrated supervisions	900,000,000
Human resources	30 continuing training sessions + 3 initial training sessions + 18 research capacity-building sessions	105,600,000
Communication	3 campaigns + 3 celebrations + 9 forums + 1 platform/website + multisectoral coordination meetings + communication plan	247,000,000
Monitoring–Evaluation–Learning (MEL)	1 semi-annual review (2 reviews × 3 years) and 1 final evaluation (first semester 2027) of NEHDP 2025–2027	74,000,000
Total	-	**1,607,600,000**

6.2 Sources of Funding

The identified funding sources include:

- The State budget, particularly through the budget lines of the Ministry of Health and allocations for Universal Health Coverage (UHC).
- International technical and financial partners (WHO, CBM, GIZ/KfW, HDI, Sightsavers, FHI 360, Swiss and Togolese Red Cross, Planète Vision, OCDI, Believe and See, BID, etc.).
- National and international NGOs, contributing through direct funding or in-kind support (equipment, consumables, technical assistance).
- The private sector, through clinics, corporate foundations, and health insurance providers.
- Community contributions, including health mutual funds, donors, patient associations, and local authorities.

6.3 Financing strategies

The financing strategies are based on the diversification and securing of resources. The plan aims to:

- Strengthen the share of public funding allocated to eye health within the national budget.
- Integrate eye care services into the benefit packages covered by Universal Health Insurance (AMU) and community-based health mutual schemes (IPEC).
- Develop innovative public–private partnerships, particularly for the procurement of equipment and the establishment of mobile services.
- Mobilize technical and financial partners through a regular consultation framework, ensuring coordination of support.
- Establish performance- and impact-based financing mechanisms.

6.4 Framework for implementation of the plan

6.4.1 Guiding principles

The implementation is based on the principles of equity, the integration of eye care into the health system, community participation, financial and institutional sustainability, and multisectoral partnership.

6.4.2 Institutional framework for implementation

The National Eye Health Program (NEHP), under the supervision of the Ministry of Health, ensures coordination and monitoring. The Regional Health Directorates and health districts are responsible for operational implementation. Hospital facilities, partner NGOs, training institutions, professional societies, local authorities, the private sector, and communities all participate in implementation according to their areas of expertise.

6.4.3 Responsibilities of stakeholders

Table 6 : Responsibilities of stakeholders

N°	Profile	Responsabilities
1	Ministry of health	Strategic orientation, budget allocation, national-level supervision, and coordination with other health programs
2	National Eye Health Program (NEHP)	Planning, technical monitoring, resource mobilization, supervision, and coordination of activities
3	Regional Health Directorates and health districts	Implementation of activities at the operational level, data collection, field supervision, and reporting
4	Public, private, and faith-based hospital facilities	Delivery of specialized services, including surgery and referral care
5	NGOs and technical and financial partners	Technical, financial, and logistical support, provision of expertise, and support for mass campaigns
6	Private sector	Complementary service provision, technological innovation, continuous training, and participation in the supply of equipment and consumables
7	Universities, faculties and training schools, professional/scientific societies	Initial and continuing training of eye health personnel (ophthalmologists, technicians, opticians, orthoptists), curriculum development, applied research, and production of evidence to inform public policies
8	Professional/scientific societies	Promotion of scientific and technical excellence, development and dissemination of evidence-based clinical guidelines and practices, contribution to continuing education and capacity building of eye health professionals, support for applied research and intervention evaluation, participation in the development of standards and protocols, facilitation of expert exchanges, and scientific coordination of activities

9	Local authorities	Community mobilization and awareness, facilitation of access to eye health services within their territory, support for local implementation of NEHDP activities, coordination with local actors (health centers, associations, NGOs), provision of municipal infrastructure for campaigns and outreach activities, and contribution to local surveillance and data reporting
10	Communities and associations of persons living with visual impairment	Social mobilization, awareness raising, advocacy, and active participation in implementation and monitoring

6.4.4 Planning and implementation

The implementation of the plan will be structured in two phases, in line with the cycle of the National Health Development Plan (NHDP) 2023–2027:

- **Phase 1 (2025–2027):** This initial phase aims to align the implementation of the Eye Health Plan with the priorities and requirements of the NHDP 2023–2027. It will focus on executing planned interventions, producing measurable results, and conducting a mid-term evaluation before 2027. This evaluation will contribute to the overall assessment of the NHDP and help identify necessary adjustments in the field of eye health.
- **Phase 2 (2028–2032):** Based on the lessons learned from Phase 1, a revision of the National Eye Health Development Plan (2025–2027) will be undertaken to align it with the new NHDP. This second phase will serve as an extension and consolidation of achievements, with medium-term strategic planning aimed at continuing efforts to reduce avoidable blindness and improve equitable access to eye care services.

Thus, the planning follows a progressive and adaptive approach, ensuring coherence between the national health strategy and specific eye health interventions, while providing the flexibility needed to incorporate innovations, reforms, and emerging priorities.

6.4.5 Success factors

The success of the National Eye Health Development Plan 2025–2027 depends on several interconnected conditions. First, strong and sustained political commitment is essential, particularly through the effective integration of eye health into national health priorities and Universal Health Coverage (UHC). Second, the availability and motivation of qualified personnel are key factors, along with a clear regulatory framework that supports the regulation of health professions and ensures service quality.

Third, the mobilization and securing of adequate financial resources are crucial, especially to ensure the sustainability of interventions beyond short-term partner support. Finally, success also depends on community ownership, the active participation of associations of persons living with visual impairment, and the establishment of strong partnerships between the public sector, the private sector, and civil society.

6.4.6 Critical assumptions

The implementation of the plan is based on a number of critical assumptions. It is assumed that the political, economic, and social context will remain sufficiently stable to allow the smooth rollout of activities across the entire territory. Support from technical and financial partners is expected to continue, and global priorities in the fight against avoidable blindness are expected to maintain sustained international attention.
It is also assumed that ongoing health system reforms (particularly the integration of services within UHC and UHI) will progress positively, thereby expanding access to eye care services. Finally, it is expected that technological advances (telemedicine, portable equipment, surgical innovations) will be gradually integrated into the national system, subject to good governance and appropriate adaptation to the local context.

6.4.7Monitoring, evaluation, and learning (MEL) mechanism

The monitoring, evaluation, and learning (MEL) mechanism of the National Eye Health Development Plan will adopt an innovative approach inspired by the concept of a learning health system (Addendum 1). Rather than being limited to mid-term or end-of-plan evaluations, the system will be designed as a continuous learning process, enabling ongoing adaptation of strategies and interventions based on observed results.

In practical terms, data will be routinely collected through the National Health Information System (DHIS2), enriched with eye health-specific indicators (e.g., cataract surgical coverage, diabetic retinopathy screening, and equity of access by sex and place of residence). These data will feed dynamic dashboards available at central, regional, and district levels, facilitating rapid, evidence-based decision-making.

The monitoring system will emphasize real-time performance analysis and the organization of quarterly performance review meetings involving all stakeholders (NEHP, regional directorates, partners, and patient associations). These reviews will help identify bottlenecks, document best practices, and implement immediate corrective actions.

A multi-stakeholder monitoring and learning committee will be established to oversee this process, ensuring transparency, accountability, and active participation from civil society and academic institutions. The approach will therefore prioritize continuous improvement, replacing rigid and spaced evaluation cycles with a permanent learning dynamic. Ultimately, this approach will strengthen the resilience and adaptability of the eye health system in response to emerging challenges.

6.5 Results Framework and Monitoring Matrix of the Plan

The results framework of this plan and its implementation monitoring matrix are presented in Annex 1 and Annex 2 respectively.

6.6 Capitalization of achievements and communication

6.6.1 Capitalization of achievements

Capitalization of achievements represents a key lever for the success and sustainability of the National Eye Health Development Plan. It makes it possible to draw lessons from past and current experiences, optimize resources, and continuously improve interventions.

6.6.1.1 Objectives of capitalization :

- Identify, document, and disseminate good practices, innovations, successes, and lessons learned from projects, programs, and activities implemented in the field of eye health in Togo over the past several years.
- Facilitate the sharing of experiences between facilities, regions, and partners.
- Ensure the dissemination of results to decision-makers and all stakeholders involved in order to guarantee continuous engagement.
- Use the lessons learned to guide strategic and technical revisions of the plan, promote innovation, and accelerate capacity building among stakeholders.

6.6.1.2 Priority activities :

- Establish a structured integrated capitalization system, including tools (databases, reports, best practice sheets) and a regular schedule for collecting feedback and lessons learned.
- Organize annual workshops, seminars, and technical conferences bringing together laboratories, technical and financial partners, as well as national and international experts.
- Set up an accessible documentation system, including for example a collaborative digital platform to facilitate exchange between stakeholders and the availability of updated tools and reference guidelines.
- Promote successful initiatives through recognition systems such as awards or certifications, in order to motivate teams and encourage a positive culture of continuous improvement.
- Integrate capitalization into the overall supervision and monitoring-evaluation framework, by combining relevant qualitative and quantitative indicators.
- Regularly produce synthesis reports and strategic briefs to be shared with health authorities, partners, and field actors, thereby facilitating informed decision-making.

6.6.2 Strategic communication

An effective communication component is essential to ensure visibility, awareness, and collective ownership of the plan by all stakeholders, both within and outside the health system.

6.6.2.1 Objectives of communication :

- Raise awareness and mobilize all stakeholders (decision-makers, health professionals, partners, and populations) around the challenges, objectives, and results of the plan.

- Promote a shared understanding of the roles and responsibilities of the various actors involved in the implementation of the plan.
- Highlight progress and achievements over time to strengthen trust and encourage continued engagement.
- Facilitate the dissemination of key messages related to quality, safety, the One Health approach, data management, and innovations.

6.6.2.2 Priority activities :

- Develop and implement a multichannel communication plan (traditional and digital media, printed materials, events) targeting different audience profiles.
- Design appropriate educational materials (branding guidelines, brochures, infographics, videos) highlighting eye health and its importance within the health system.
- Regularly celebrate World Eye Health Days.
- Organize national eye health days, technical forums, and regional workshops to strengthen exchanges and partnerships.
- Develop an internal communication strategy to enhance the engagement of eye health professionals and improve the organizational climate.
- Collaborate with local media and influencers to increase the reach of messages, particularly in rural areas and among vulnerable groups.
- Establish a digital information and exchange platform to disseminate news, technical documents, results, and best practices.
- Ensure monitoring and evaluation of communication activities in order to measure their impact and adjust messages and channels as needed.

7 ANNEXES

Operational plan

The timeline presented in this annex covers the entire strategic period of the National Eye Health Development Plan (NEHDP) up to 2032. However, the detailed operational breakdown is presented only for Phase 1 (2025–2027), in accordance with the alignment directives of the 2023–2027 National Health Development Plan (NHDP). Phase 2 will be revised and updated in 2028 based on the results achieved and lessons learned from the first phase.

Annexe 1 : Results Framework Matrix – PNDSO 2025–2027 (by component)

Annexe 1 : Results Framework Matrix – PNDSO 2025–2027 (by component)

N°	Product / Immédiate result expected	Indicator	Unit	Source	2024	2025	2026	2027	Responsible party(ies)	Means / Resources	Observations
Component 1 – Human resources											
1.1	The capacities of eye health human resources are strengthened.	Percentage of districts with trained eye care personnel	%	Reports DHR/MHPH, NEHP	35	45	55	65	DHR/MHPH, NEHP	Training budget, academic partnerships	Depends on funding
1.2	Effective recruitment and deployment of ophthalmology specialists	Number of ophthalmologists per million inhabitants	Ratio	Annuaire statistique MHPH	2,5	3	3,5	4	DHR/MHPH, NEHP	State funds, partner support	WHO target = 4 per million inhabitants
Component 2 – Infrastructure and equipment											
2.1	Eye care infrastructures are developed and modernized.	Percentage of districts/municipalities with functional eye care units	%	NEHP reports, GDH	40	50	65	80	DISEM/MSHP, NEHP	Investment budget, NGO donations	Depends on public funding
2.2	Ophthalmic equipment is upgraded and properly maintained.	Number of regional hospitals equipped with modern equipment	Numbers	Inventory NEHP equipments	1	3	4	5	DISEM/NEHP	Equipment, maintenance contracts	Annual monitoring required
Component 3 – Prevention and control of eye diseases											
3.1	Cataract surgery is strengthened	Cataract Surgical Rate (CSR)	Cases/million inhab.	DHIS2, surgical registers	1200	1500	1800	2000	NEHP, Hospitals	State funds, NGO support, surgical kits	Achievement depends on trained personnel
3.2	Childhood eye diseases are better managed.	Percentage of schools covered by vision screening programs	%	School reports, NEHP	15	30	50	70	NEHP, Education	State budget, UNICEF/NGO support	Depends on intersectoral synergy

3.3	Diabetic retinopathy is integrated into care management.	• Number of diabetic patients screened	Numbers	Diabetology reports & NEHP	5 000	10 000	15 000	20 000	NEHP, MNT Program	Screening tests, fundus examination equipment	Integration of non-communicable diseases (NCDs)–eye health
Component 4 – Multisectoral coordination and governance											
4.1	The institutional framework for eye health is strengthened.	Existence of a functional national multisectoral committee	Oui/Non	NEHP reports, MHPH	No	Yes	Yes	Yes	MHPH, NEHP	Decrees, meetings, operating budget	Ensure intersectoral participation
4.2	Governance and coordination mechanisms are operational.	Number of multisectoral coordination meetings held per year	Nombre	NEHP reports, MHPH	0	2	3	4	NEHP, partners	Operating budget, logistics	Include civil society & NGOs
4.3	Monitoring, evaluation, and learning (MEL) of the NEHDP are institutionalized.	Percentage of annual reports produced and disseminated	%	NEHP reports	0	70	85	100	NEHP, SEA Unit MSHP	DHIS2 system, human resources	Requires technical support
Component – 5 Eye health research											
5.1	A national applied research program in eye health is operational.	Existence of a validated national research agenda	Yes/No	NEHP reports	No	Elaboration	Validation	Implementation	NEHP, Universities	Academic support, funding	Depends on government approval
5.2	Research findings are disseminated and used to inform policy development.	Number of studies published and used for decision-making	Numbers	NEHP reports, academic institutions	0	2	4	6	NEHP, Universities, Partners	Research funding, conferences	Promote knowledge transfer

Annexe 2 : NEHDP Results Framework 2025-2027

Annexe 2 : NEHDP Results Framework 2025-2027

Expected Effect / Change	Expected Output / Immediate Result	Indicator	Unit	Source	2024	2025	2026	2027	Responsible Party(ies)	Means / Resources	Observations
Priority 1 : Human resources											
Outcome 1: National eye health human resource capacities are strengthened and better distributed	The capacities of eye health human resources are strengthened.	Percentage of districts with personnel trained in eye care services	%	DHR/ MHPH reports, NEHP	35	45	55	65	DHR/MHPH, NEHP	Training budget, academic partnerships	Depends on funding
	Effective recruitment and deployment of ophthalmology specialists.	Number of ophthalmologists per million inhabitants	Ratio	Statistical Yearbook, Ministry of Health (MHPH)	2,5	3	3,5	4	DHR/MHPH, NEHP	State funds, partner support	WHO target = 4/million inhab.
Priority 2 : Infrastructure & equipment											
Outcome 2: Eye care services are accessible, modernized, and functional	Eye care infrastructures are developed and modernized.	Percentage of districts with functional eye care units	%	NEHP reports, GDH	40	50	65	80	GDH/MHPH, NEHP	Investment budget, NGO donations	Depends on public fundings

	Ophthalmic equipment is upgraded and maintained.	Number of regional hospitals equipped with modern equipment	Numbers	NEHP equipment inventory	1	3	4	5	GDH, NEHP	Equipment, maintenance contracts	Annual monitoring required
Priority 3: Prevention and management											
Outcome 3: Major eye diseases are effectively managed	Cataract surgery is strengthened.	Cataract Surgical Rate (CSR)	Cases per million inhabitants.	DHIS2, surgical registers	1200	1500	1800	2000	NEHP, Hospitals	State funds, NGO support, surgical kits	Achievement depends on trained personnel.
	Child eye diseases are better managed.	Percentage of schools covered by vision screening	%	School reports, NEHP	15	30	50	70	NEHP, Education	State budget, UNICEF/NGO support	Depends on intersectoral synergy
	Diabetic retinopathy is integrated into care management.	Number of diabetic patients screened	Numbers	Diabetology reports & NEHP	5 000	10 000	15 000	20 000	NEHP, NCD (Non-Communicable Diseases) program	Screening tests, fundus examination equipment	Integration of NCDs (non-communicable diseases) and eye health.
Priority 4 : Multisectoral coordination and governance											
Outcome 4: The eye health governance and	The institutional framework for eye health is strengthened.	Existence of a functional national multisectoral committee	Yes/No	NEHP reports, MHPH	No	Yes	Yes	Yes	MHPH, NEHP	Decrees, meetings, operating budget.	Ensure intersectoral participation.

coordination system is efficient, inclusive, and sustainable.											
	The governance and coordination mechanisms are operational.	Number of multisectoral coordination meetings held per year.	Numbers	NEHP reports, MHPH	0	2	3	4	NEHP, partners	Operating budget, logistics.	Include civil society & NGOs.
	The monitoring and evaluation of the PNDSO is institutionalized.	• Percentage of annual reports produced and disseminated	%	NEHP reports	0	70	85	100	NEHP, MHPH Monitoring and Evaluation Unit	DHIS2 system, human resources	Requires technical support
Priority 5 (Transversal) : Eye health research											
Outcome 5: Research informs eye health policies and interventions.	A national applied research program in eye health is operational.	Existence of a validated national research agenda.	Yes/No	NEHP reports	No	Elaboration	Validation	Implementation	NEHP, Universities	Académic support, fundings	Depends on governmen t's validation
	Research results are disseminated and used to inform policy.	Number of studies published and used for decision-making.	Numbers	NEHP reports, academic institutions.	0	2	4	6	NEHP, Universities, Partners	Research funding, conferences.	Promote knowledge transfer.