PMI | U.S. PRESIDENT'S MALARIA INITIATIVE

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This Malaria Operational Plan has been approved by the U.S. Global Malaria Coordinator and reflects collaborative discussions with the national malaria control programs and partners in country. The funding available to support the plan outlined here is pending finalization of the FY 2020 appropriation. If any further changes are made to this plan it will be reflected in a revised posting.

U.S. PRESIDENT'S MALARIA INITIATIVE

BURKINA FASO

Malaria Operational Plan FY 2020

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ABBREVIATIONS

ACT	Artemisinin-based combination therapy
AL	Artemether-lumefantrine
ANC	Antenatal care
AS/AQ	Artesunate-amodiaquine
AS-Pyr	Artesunate Pyronaridine
BMGF	Bill & Melinda Gates Foundation
CAMEG	Central Medical Stores
CDC	U.S. Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CNRFP	National Center for Research and Training on Malaria
CSPS	*Centre de Santé et de Promotion Sociale*
CY	Calendar year
DHS	Demographic and Health Survey
DGPML	*Direction Générale de la Pharmacie, Médicine et Laboratoire*
ENDOS-BF	*Entrepôt de données sanitaires du Burkina Faso*
EPI	Expanded Program on Immunization
FETP	Field Epidemiology Training Program
FY	Fiscal year
GHI	Global Health Initiative
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoBF	Government of Burkina Faso
IEC	Information, education, communication
IPTp	Intermittent preventive treatment for pregnant women
IRS	Indoor residual spraying
ITN	Insecticide-treated mosquito net
MIP	Malaria in pregnancy
MIS	Malaria indicator survey
MoH	Ministry of Health
MOP	Malaria Operational Plan
NMCP	National Malaria Control Program
NSP	National Strategic Plan
PMI	U.S. President's Malaria Initiative
QA/QC	quality control/quality assurance
RDT	Rapid diagnostic test
TRaC	Tracking results continuously
SARA	Service Availability and Readiness Assessment
SBC	Social and behavior change
SMC	Seasonal malaria chemoprevention
SM&E	Surveillance, monitoring, and evaluation

SP	Sulfadoxine-pyrimethamine
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

I. INTRODUCTION

The U.S. President's Malaria Initiative (PMI)—led by the U.S. Agency for International Development (USAID) and implemented together with the U.S. Centers for Disease Control and Prevention (CDC)—delivers cost-effective, lifesaving malaria interventions alongside catalytic technical and operational assistance to support Burkina Faso to end malaria. PMI has been a proud partner of Burkina Faso since fiscal year (FY) 2010. In FY 2017, PMI elevated Burkina Faso to PMI focus country status and increased its annual investment. Between FY 2010 and FY 2019, PMI has invested more than $115 million to help the country fight malaria.

The proposed PMI fiscal year (FY) 2020 budget for Burkina Faso is $23 million. This Malaria Operational Plan (MOP) outlines planned PMI activities in Burkina Faso for FY 2020. Developed in consultation with the National Malaria Control Program (NMCP) and key stakeholders, proposed activities reflect national and PMI strategies, draw on best-available data, and align with the country context and health system. Proposed PMI investments support and build on those made by the Government of Burkina Faso as well as other donors and partners.

Burkina Faso at a glance

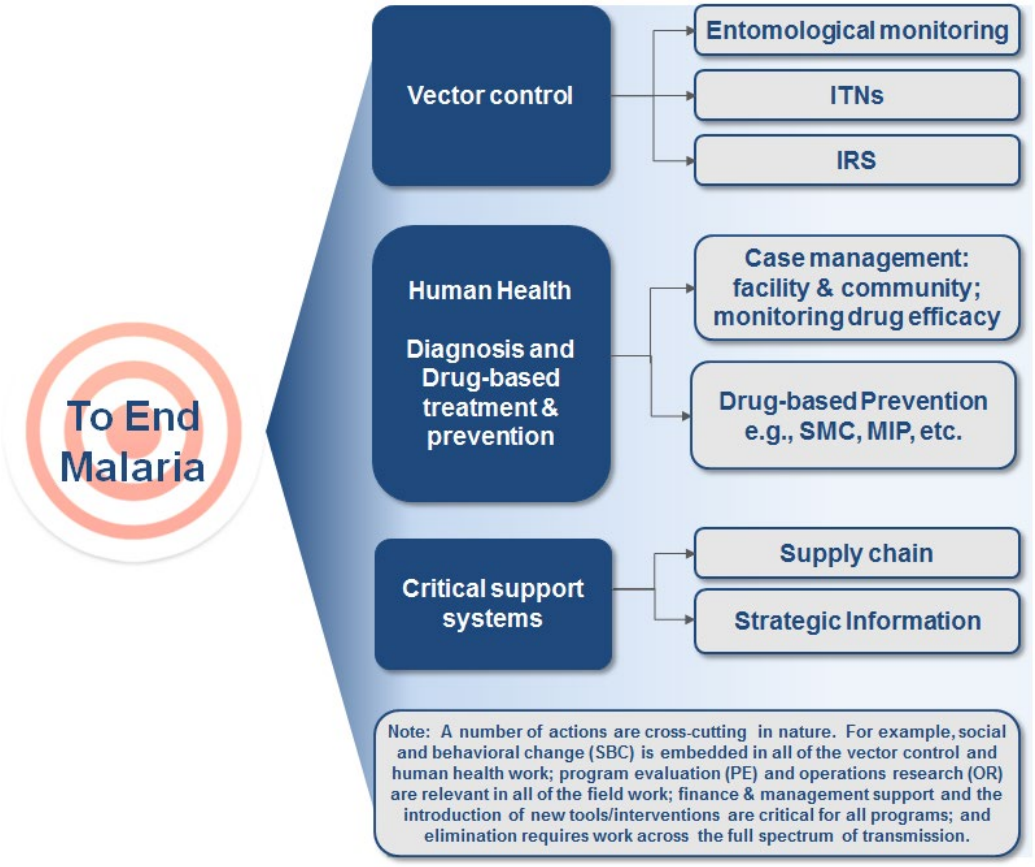
- **Geography:** Landlocked Sahel country in central West Africa; 20 percent of the population lives in urban areas
- **Climate:** Rainy season typically June-October, with three distinct climate zones ranging in rainfall intensity
- **Population in 2019:** 20.87 million (NSP 2019-2020)
- **Population at risk of malaria:** 20.87 million (NSP 2019-2020)
- **Principal malaria parasites:** P. *falciparum* (World Malaria Report 2018)
- **Principal malaria vectors:** Members of the *Anopheles gambiae* complex are the principal vectors. In the western and southern part of country *An. gambiae* s.s. predominates, *An. coluzzii* in the north central and eastern region with *An. arabiensis* interspersed. (NSP 2019-2020)
- **Malaria incidence per 1000 population:** 607 (NSP 2019-2020)
- **Under-five mortality rate per 1000 live births:** 81.2 (UNICEF, 2018)
- **Income Classification:** Low income, GDP $14.4 billion (World Bank, 2018)
- **Political system:** Semi-presidential republic
- **Trafficking in Persons designations, 2016-2018:** Tier 2 (U.S. State Department, 2019)
- **Malaria funding and program support partners include (but are not limited to):**
    - U.S. President's Malaria Initiative (PMI)
    - Global Fund to Fight AIDS, Tuberculosis and Malaria
    - Bill & Melinda Gates Foundation
    - World Health Organization (WHO)
    - Malaria Consortium

- United Nations Children's Fund (UNICEF)
- Clinton Health Access Initiative (CHAI)
- World Bank

- **PMI Support of National Malaria Control Strategy:** Approximately $24 million per year to support key malaria control interventions (See III. *Overview of PMI's support of Burkina Faso's Malaria Control Strategy* for additional details)
- **PMI Investments:** Burkina Faso began implementation as a PMI focus country in FY 2017. The proposed FY 2020 PMI budget for Burkina Faso is $23 million, which brings the total PMI investment to almost $140 million.

PMI organizes its activities and planning levels around the areas below in Figure 1, in line with the national malaria strategy.

Figure 1. PMI's Approach to End Malaria



PMI's approach aligns with and contributes to USAID's Journey to Self-Reliance framework. Building and strengthening the capacity of Burkina Faso's people and institutions – from the central level to communities – to effectively lead and implement evidence-based malaria control and elimination activities remains paramount to PMI. As denoted in Table 2 (the budget table), PMI's planned support for FY 2020 promotes capacity building and system strengthening across

technical areas. PMI/Burkina Faso will continue to rely on and engage with key agencies of the Ministry of Health such as the NMCP, the General Directorate for Public Health (and its relevant component directorates for population health, health education, family health, and the national public health laboratory), the General Directorate for Statistical Studies and its relevant component directorates for health statistics and health information systems, the General Directorate for Access to Health Commodities, the National Agency for Pharmaceutical Regulation, the Central Medical Stores (CAMEG), the Directorate for Communication, the Technical Secretariat for the Elimination of Priority Diseases, National Center for Research and Training on Malaria (CNRFP), and the National Public Health Institute, and is expanding its local partner base to reach local NGOs and other sections within the Ministry of Health such as the Emergency Operations Center. Finally, PMI/Burkina Faso will continue to rely on private sector partnerships such as with private clinics.

It is important to note that Burkina Faso's security situation has deteriorated in the past year, with violent extremist attacks destabilizing the country and resulting in about 500,000 internally displaced people. The escalating humanitarian crisis will necessitate a change in the strategy of PMI and other partners from more traditional capacity building to humanitarian assistance/emergency response to limit the interruption of access to prevention and curative services for the population. Additionally, activities must be adapted to ensure the security of those implementing activities in the field.

To accelerate the journey to self-reliance, PMI developed a programmatic inventory to assess the strengths and challenges in Burkina Faso's program (see Annex B). The activities proposed in this MOP are designed to draw on these strengths and address any gaps. PMI understands it will take time before Burkina Faso can fully finance its development priorities. PMI will work with other partners (e.g., the Global Fund) to track Burkina Faso's funding commitments across the malaria portfolio.

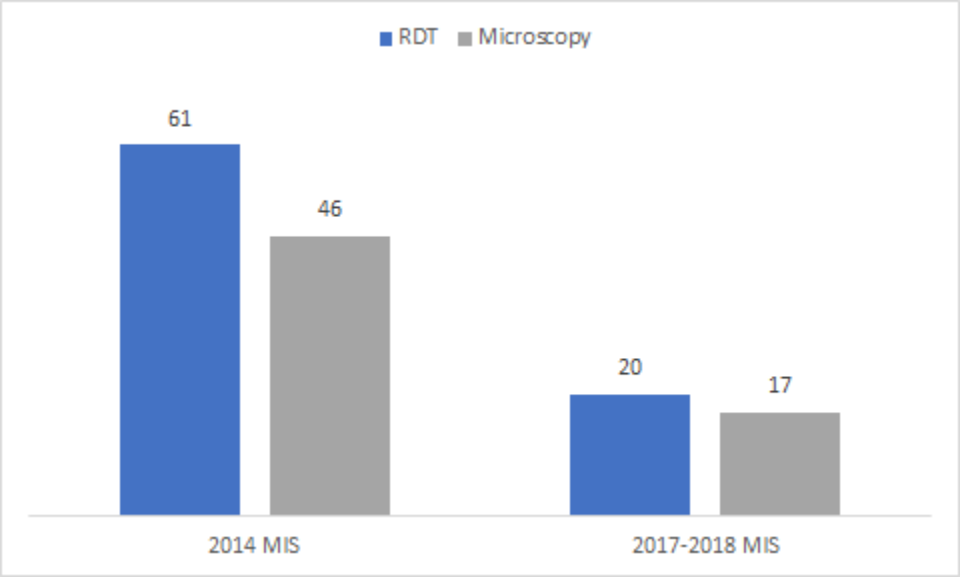
II. MALARIA SITUATION AND MALARIA CONTROL PROGRESS IN BURKINA FASO

Malaria is a major health issue in Burkina Faso. Malaria is endemic throughout the country with a seasonal upsurge from June through October. This seasonal peak is variable across the three major geographic zones linked with the duration of the rainy season; up to three months in the north, six months in the Center, and nine months in the South.

Routine Ministry of Health data show that there were 11,970,321 reported malaria cases (presumed and confirmed, with 88.4 percent confirmed by RDT or microscopy) in 2018 compared to 11,915,816 cases in 2017 (with 88.35 percent confirmed cases). In 2018, there were 4,296 deaths linked to malaria in comparison with 4,144 deaths in 2017.

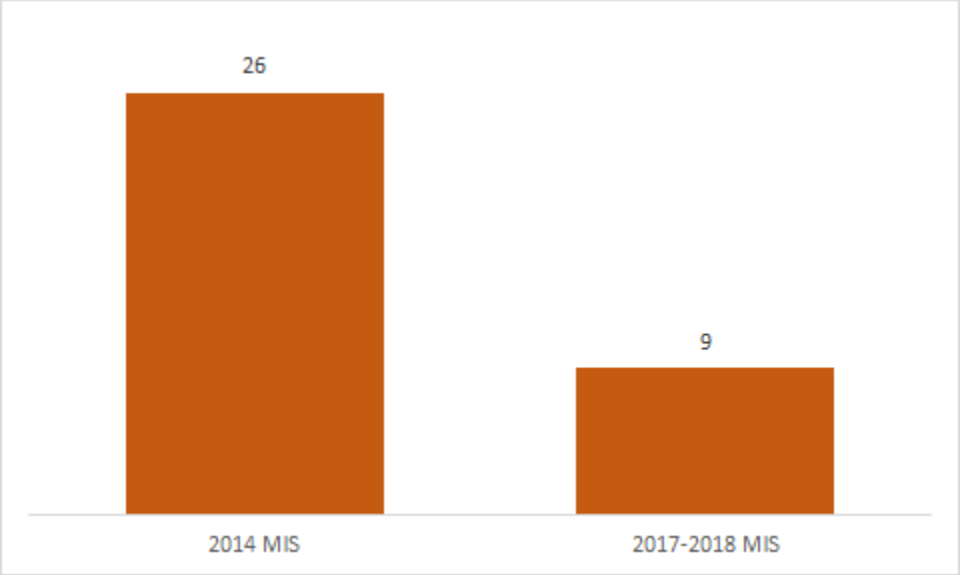
In 2017[1] Burkina Faso was among the seven countries accounting for 53 percent of all global malaria deaths. Burkina Faso was ranked in third position with six percent of all global malaria deaths with Nigeria (19 percent) and Democratic Republic of Congo (11 percent).

Figure 2. Trends in Malaria Prevalence, *Percent of Children Age 6-59 Months who Tested Positive for Malaria by Microscopy and RDT*



*Note that the 2017-2018 MIS was implemented in the low-transmission season, while the 2014 survey was implemented in the high transmission season, therefore these data cannot be directly compared

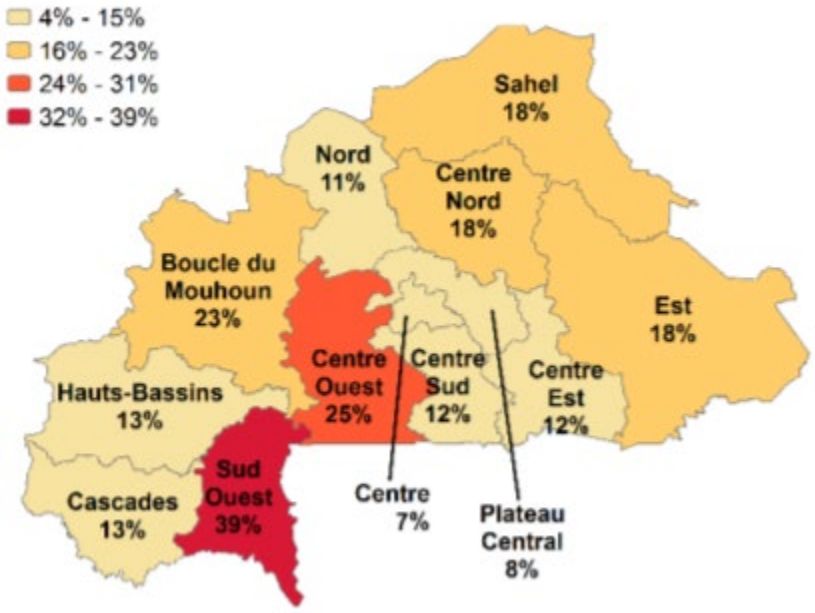
Figure 3. Trends in Prevalence of Low Hemoglobin, *Percent of Children Age 6-59 Months with Moderate-to Severe Anemia (Hemoglobin < 8,0 g/dl)*



*Note that the 2017-2018 MIS was implemented in the low-transmission season, while the 2014 survey was implemented in the high transmission season, therefore these data cannot be directly compared

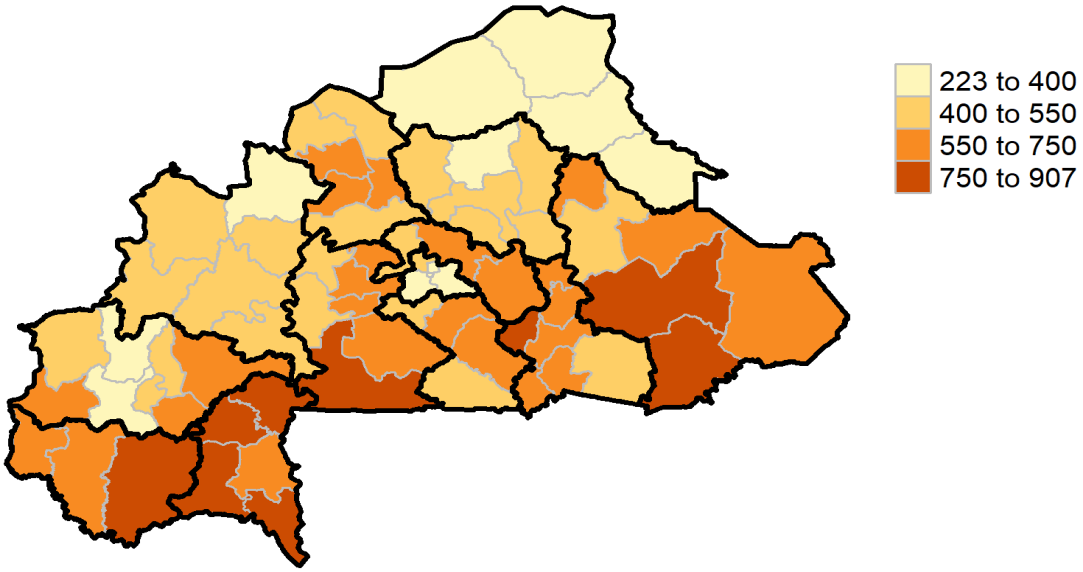
[1] World malaria report 2018

Figure 4. Malaria Parasite Prevalence among Children Under Five Years of Age by Geographic Area, *Percent of Children Age 6-59 Months Who Tested Positive for Malaria by Microscopy*



Source: 2017-18 MIS, implemented in the low-transmission season

Figure 5. Confirmed Malaria Cases per 1,000 Population in 2018 by District



Source: HMIS Data

Figure 6. Key indicators for malaria prevention and treatment coverage and impact indicators from Demographic Health Surveys (DHS) and Malaria Indicator Surveys (MIS) from 2014-2018

Indicator	2014 MIS	2017-18 MIS
% Households with at least one ITN	90	75
% Households with at least one ITN for every two people	49	33
% Population with access to an ITN	71	55
% Population that slept under an ITN the previous night	67	44
% Children under five years old who slept under an ITN the previous night	75	54
% Pregnant women who slept under an ITN the previous night	77	58
% Children under five years old with fever in the last two weeks for whom advice or treatment was sought[1]	61	74
% Children under five with fever in the last two weeks who had a finger or heel stick[2]	30	49
% Children receiving an ACT among children under five years old with fever in the last two weeks who received any antimalarial drugs[2]	28	79
% Women who received two or more doses of IPTp during their last pregnancy in the last two years	48	82
% Women who received three or more doses of IPTp during their last pregnancy in the last two years	22	58
Under-five mortality rate per 1,000 live births	129 (2010 DHS)	
% Children under five years old with parasitemia (by **microscopy,** if done)	46	17
% Children under five years old with parasitemia (by **RDT**, if done)	61	20
% Children under five years old with severe anemia (Hb<8gm/dl)	26	9

[1]Note that this indicator has been recalculated according to the newest definition, at the specified number of doses of SP/Fansidar from any source, wherever possible

[2]Note that this indicator has been recalculated according to the newest definition, care or treatment from any source excluding traditional practitioners, wherever possible

Figure 7. Evolution of Key Malaria Indicators Reported through Routine Surveillance Systems

	2014	2015	2016	2017	2018
# Suspect malaria cases[1]	n/a	n/a	n/a	n/a	15,339,224
# Patients receiving diagnostic test for malaria[2]	n/a	n/a	n/a	n/a	13,636,115
Total # malaria cases[3] (confirmed and presumed)	8,278,408	8,285,251	10,629,272	11,915,816	11,970,321
# Confirmed cases[4]	5,428,003	7,014657	9,785,822	10 527 304	10,589,000
# Presumed cases[5]	2,850,405	1,270,594	843,450	1,388,512	1,381,321
% Malaria cases confirmed[6]	65.67%	84.7%	92.1%	88.3%	88.5%
Test positivity rate (TPR)[7]	85%	87%	82%	81%	77%

	2014	2015	2016	2017	2018
Total # <5 malaria cases[8]	894,247	3,688,077	4,970,689	6,082,216	5,870,314
% Cases under 5[9]	10.8%	44.5%	46.8%	51%	49%
Total # severe cases[10]	n/a	n/a	n/a	n/a	506 513
Total # malaria deaths[11]	5,632	5,379	3,974	4,144	4,296
# Facilities reporting[12]	n/a	n/a	n/a	n/a	2 648
Data form completeness (%)[13]	98%	92%	95%	94%	93%

Data sources and comments:

N/A = not available

Definitions:

1 Number of patients presenting with signs or symptoms considered to be possibly due to malaria (e.g., this could be the number of patients presenting with fever or history of fever in the previous 24 or 48 hours)

2 Number of patients receiving a diagnostic test for malaria (RDT or microscopy). All ages, outpatient, inpatient

3 Total # cases: Total number of reported malaria cases. All ages, outpatient, inpatient, confirmed and unconfirmed cases.

4 # confirmed cases: Total diagnostically confirmed cases. All ages, outpatient, inpatient.

5 # presumed cases: Total clinical/presumed/unconfirmed cases. All ages, outpatient, inpatient.

6 % Malaria Cases confirmed: # confirmed cases (#4 above) / Total # cases (#3 above)

7 TPR: Number of confirmed cases (#4 above)/Number of patients receiving a diagnostic test for malaria (RDT or microscopy) (#2 above)

8 Total #<5 cases: Total number of <5 cases. Outpatient, inpatient, confirmed, and unconfirmed.

9 Total # <5 cases (#8 above) / Total # of cases (# 3 above)

10 As there may not be a standard definition across countries, please specify if there is such a variable available and the definition that is used; if "severe malaria" is not used or collected but "hospitalized for malaria" is a standard in the country, please insert that label and the relevant data by year.

11 Total # Malaria Deaths Reported: All ages, outpatient, inpatient, confirmed, and unconfirmed.

12 Total # of health facilities reporting data into the HMIS/DHIS2 system for that year.

13 Data completeness: Number of monthly reports received from health facilities/Number of health facility reports expected (i.e., number of facilities expected to report multiplied by the number of months considered).

III. OVERVIEW OF PMI'S SUPPORT OF BURKINA FASO'S MALARIA CONTROL STRATEGY

The current National Strategic Plan (NSP) for malaria control that covers the 5-year period from 2016-2020 draws from the overall National Plan for Economic and Social Development 2016-2020, which places specific emphasis on malaria control and is in line with the Government of Burkina Faso's (GoBF) long-term vision of eliminating malaria in Burkina Faso by 2030. The NSP 2016-2020 objectives align with the WHO's Global Technical Strategy and PMI's Strategy for 2015-2020 and include:

- Reduce malaria death rate by 40 percent in Burkina Faso by 2020 from 2015 levels
- Reduce malaria incidence rate by 40 percent in Burkina Faso by 2020 from 2015 levels
- Reinforce NMCP malaria program management capacities in Burkina Faso by 2020

The NSP 2016 – 2020 emphasizes 10 focus areas:

- Parasitological diagnosis of malaria at public and private health facilities, community levels, and through quality control/quality assurance (QA/QC) of laboratories

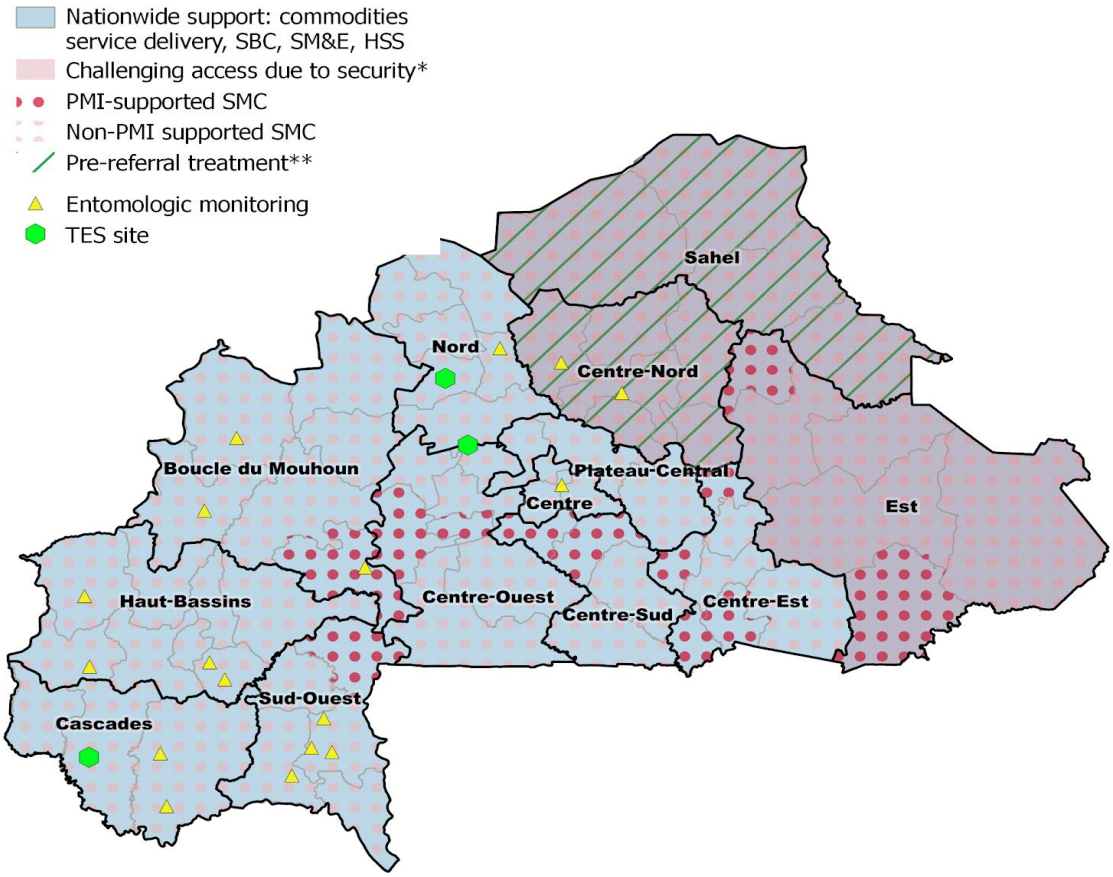
- Treatment of malaria cases at public and private health facilities as well as at the community level
- Vector control through universal access to ITNs, implementation of IRS in targeted areas, and management of insecticide resistance
- Prevention of malaria in pregnancy (MIP) using IPTp with Sulfadoxine-pyrimethamine (SP) and by providing ITNs through routine distribution channels
- Seasonal malaria chemoprevention (SMC) for children aged 3-59 months
- Strengthening of communication through advocacy and social and behavior change
- Strengthening commodity supply chain management
- Monitoring, evaluation, and research
- Epidemic control and emergency management
- Strengthening malaria program management

Of the 10 focus areas highlighted in the NSP 2016 – 2020, eight are aligned with PMI-supported key intervention areas and receive varying levels of PMI funds. Epidemic control and emergency management as well as malaria program management are focus areas of the NSP that have not to date benefited from PMI support.

The NMCP is already in the process of drafting the next NSP (2021 – 2025) with an advanced draft expected in March 2020 for inclusion in the GoBF application for the next cycle of the Global Fund subsidy.

Figure 8 below demonstrates the geographical scope of PMI-supported interventions that are mostly national in their reach. Focus on specific geographical areas is intervention-related, rather than a concerted partitioning of the country to specific partners for malaria control.

Figure 8. PMI Intervention Support Map: FY2020



**Most challenging areas to access due to security as of January 2020*, however the entire country is categorized Level 4 by the State Department.
***Districts in which PMI will support pre-referral treatment may change based on epidemiology and security*

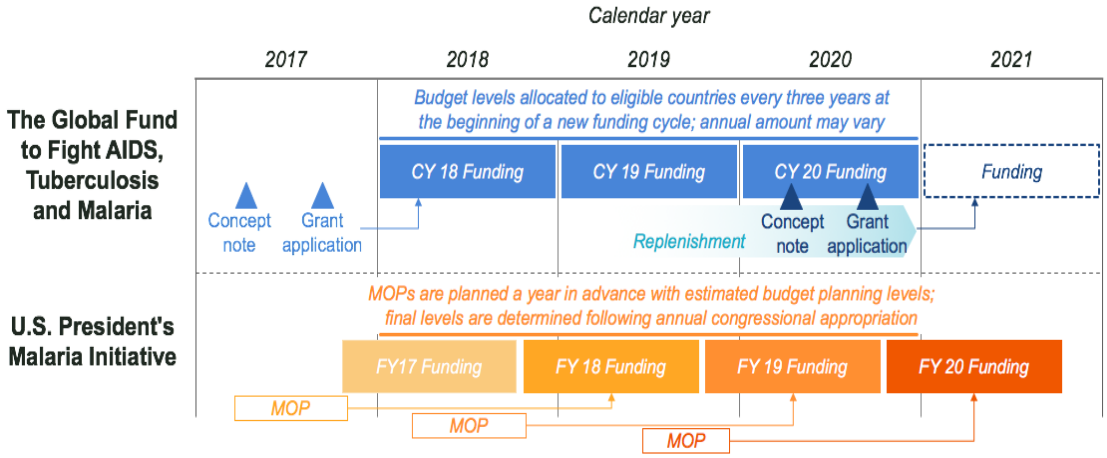
IV. PARTNER FUNDING LANDSCAPE

PMI emphasizes the importance of partner alignment on malaria control. With the recognition that each emphasizes complementary funding support for the national malaria control effort in a given country, over the last year, PMI, the Global Fund, and the Bill & Melinda Gates Foundation set out to harmonize financial, supply chain, and programmatic data, and this effort remains ongoing at the time of this MOP. A harmonized financial taxonomy has been developed for PMI and the Global Fund (i.e. mapping cost categories across organizations).

Figure 9 visualizes the annual cycle of PMI funding and the MOP implementation year. As the figure illustrates, any given FY MOP funds activities that take place during the next FY. For example, a FY18 MOP funds implementation during FY19. Whereas Global Fund funding (and often, other partners and host country governments) is based on a three-year grant cycle on a calendar year (CY) timeframe during which activities were implemented. Annual PMI country budget allocations depend largely on the U.S. Congress' total overall malaria funding appropriation to USAID in a given fiscal year, as well as other considerations (e.g. previous

funding levels, activity and program pipelines, other donor contributions, known commodity needs/gaps, progress on ongoing PMI-supported activities, clear evidence of continued government commitment to malaria control).

Figure 9. PMI and Global Fund Funding Cycle Alignment



Footnote: In some cases, Global Fund's funding may come in partway through the calendar year. Funding levels in "Section IV - Partner Funding Landscape" and commodity procurement amounts listed in "Annex A - Intervention Specific Data" may differ given the lag between the year that funding was planned and the year when procurement orders were placed. Differences may be a reflection of timing and/or based on changes in commodity consumption levels at country level, changes in commodity costs, or other donor orders.

Figures 10 and 11 summarize contributions by external partners and host country government in calendar years 2018-20, with the goal of highlighting total country investments. For Burkina Faso, data is available for PMI (FY 2018) and Global Fund (CY 2018-20). As the Global Fund 2021-23 grant funding cycle is not yet underway at the time of this PMI FY20 MOP development, Global Fund country investments for the 2021 implementation period and beyond are not yet known. Note that the host country government invests substantial funding into the national-to-local infrastructure and service delivery for malaria and many other programs. However, there has not been a standardized method for attributing those investments to malaria specifically. Thus, it may not yet be possible in the FY 2020 MOP cycle to attribute funding from the host country government. There may be similar challenges for other partners.

Figure 10. Annual Budget by Level 1 Category

Year[1]	Funder	Vector Control	Case Management	Drug-Based prevention[2]	Supply Chain[3]	Monitoring, Evaluation & Research	Other Cross-Cutting and Health Systems Strengthening	Total
FY17/CY18	PMI	$4.6M	$13.2M	$2.7M	$1.6M	$0.9M	$1.9M	**$25.0M**
	Global Fund	$15.8M	$5.8M	$1.8M	$0.2M	$1.4M	$5.0M	**$30.1M**
	Total	**$20.4M**	**$19.1M**	**$4.5M**	**$1.9M**	**$2.3M**	**$7.0M**	**$55.1M**

Year[1]	Funder	Vector Control	Case Management	Drug-Based prevention[2]	Supply Chain[3]	Monitoring, Evaluation & Research	Other Cross-Cutting and Health Systems Strengthening	Total
FY18/CY19	PMI	$4.9M	$10.8M	$3.5M	$1.9M	$1.0M	$2.8M	**$25.0M**
	Global Fund	$25.1M	$5.0M	$5.4M	$1.1M	$3.2M	$8.7M	**$48.5M**
	Total	**$30.0M**	**$15.8M**	**$8.9M**	**$3.0M**	**$4.2M**	**$11.5M**	**$73.5M**
FY19/CY20	PMI	$3.7M	$11.4M	$3.4M	$1.6M	$.3M	$2.6M	**$23.0M**
	Global Fund	$4.3M	$1.7M	$11.0M	$.4M	$2.8M	$9.5M	**$29.6M**
	Total	**$8.0M**	**$13.1M**	**$14.4M**	**$2.0M**	**$3.1M**	**$12.1M**	**$52.6M**

Footnotes:

1. Each year's figures represent the FY for PMI and CY for GFATM that most closely align. Global Fund budget data accurate as of July 1, 2019. PMI budget data accurate as of Sept 1, 2019.
2. Drug-based prevention, including SMC and MIP where relevant;
3. Covers management of in-country warehousing & distribution of malaria commodities, except for ITNs which are separately captured under "Vector Control"

Note: Categories shown reflect the harmonized financial taxonomy (Levels 1-3) developed by BMGF, Global Fund, and PMI in 2019, as part of a broader data harmonization initiative; potential for categories to continue to evolve through FY 2020 MOP process, as well as for additional donors and host country governments to adopt and reflect funding using same categories.

Figure 11. Annual Budget by Level 3 Category, Detailed Breakdown for PMI and Global Fund

Level 1 Category	Level 3 Category	FY17/CY18[1]		FY18/CY19[1]		FY19/CY20[1]	
		PMI	Global Fund	PMI	Global Fund	PMI	Global Fund
Vector Control	Procure ITNs for Continuous Distribution	$0.2M	-	-	-	-	$2.3M
	Distribute ITNs via Continuous Distribution	-	-	-	-	-	-
	Procure ITNs for Mass Campaigns	-	$14.6M	-	$13.1M	-	-
	Distribute ITNs via Mass Campaigns	-	$0.01M	-	$5.3M	-	-
	Other ITN Implementation*	$0.1M	-	$0.1M	-	-	-
	IRS Implementation[4]	$4.0M	-	$4.1M	-	$3.1M	-
	Procure IRS Insecticide[4]	-	-	-	-	-	-
	Other IRS*	-	-	$0.0M	-	-	-

Level 1 Category	Level 3 Category	FY17/CY18[1]		FY18/CY19[1]		FY19/CY20[1]	
		PMI	Global Fund	PMI	Global Fund	PMI	Global Fund
	Entomological Monitoring	$0.4M	-	$0.7M	-	$0.6M	-
	SBC for Vector Control[5]	-	$1.0M	-	$1.2M	-	$1.1M
	Other vector control measures	-	-	-	-	-	-
	Removing human rights- and gender-related barriers to vector control programs**	-	-	-	-	-	-
Case Management	Active Case Detection**	-	-	-	-	-	-
	Community-based case management	-	-	-	-	-	-
	Facility-based case management	-	-	-	$0.02M	-	$0.02M
	Private-sector case management	-	-	-	-	-	-
	Procure ACTs	$6.3M	$1.0M	$5.4M	$1.9M	$4.9M	-
	Procure Drugs for Severe Malaria	$1.2M	$2.9M	$1.5M	$0.0M	$2.2M	-
	Procure Other Diagnosis-Related Commodities	-	-	-	-	-	-
	Procure Other Treatment-Related Commodities	-	-	-	-	-	-
	Procure RDTs	$4.2M	$0.9M	$3.6M	$0.9M	$4.0M	$1.1M
	Therapeutic Efficacy	-	-	-	-	$0.2M	-
	SBC for Case Management[5]	-	-	-	-	-	-
	Other Case Management	$1.5M	-	$0.4M	-	$0.3M	-
Drug-Based Prevention[2]	Procure SMC-Related Commodities	$0.9M	$0.7M	$1.2M	$2.8M	$1.3M	$0.8M
	SMC Implementation	$1.7M	$1.0M	$2.2M	$1.8M	$2.0M	$9.7M
	Prevention of Malaria in Pregnancy Implementation	-	-	$0.1M	-	$0.1M	-

Level 1 Category	Level 3 Category	FY17/CY18[1]		FY18/CY19[1]		FY19/CY20[1]	
		PMI	Global Fund	PMI	Global Fund	PMI	Global Fund
	Procure IPTp-Related Commodities	$0.1M	-	-	-	-	-
	IPTi**	-	-	-	-	-	-
	SBC for Drug-Based Prevention[5]	-	-	-	-	-	-
	Other Prevention**	-	-	-	-	-	-
Supply Chain[3]	In-Country Supply Chain[3]	$0.6M	-	$0.3M	-	$0.4M	-
	Supply Chain Infrastructure	-	-	-	-	-	-
	Ensuring Quality	-	-	-	-	-	-
	Pharmaceutical Management Systems Strengthening	$1.0M	-	$1.6M	-	$1.2M	-
	Supply Chain System Strengthening	-	$0.2M	-	$1.1M	-	$0.4M
Monitoring, Evaluation & Research	Reporting, Monitoring, and Evaluation	$0.7M	$1.0M	$0.3M	$2.5M	$0.3M	$1.5M
	Program and data quality, analysis, and operations research	$0.1M	$0.01M	-	$0.2M	-	$0.0M
	Surveys	$0.1M	$0.1M	$0.6M	$0.5M	-	$1.0M
	Other Data Sources**	-	$0.2M	-	$0.03M	-	$0.3M
	Support for FETP*	-	-	$0.1M	-	$0.03M	-
Other Cross-Cutting and Health Systems Strengthening	Integrated service delivery, quality improvement, and national health strategies**	-	$0.8M	-	$2.6M	-	$3.5M
	Financial management systems**	-	$0.3M	-	$0.3M	-	$0.4M
	Community responses and systems**	-	-	-	-	-	-
	Support for PCV and SPAs*	-	-	-	-	-	-

Level 1 Category	Level 3 Category	FY17/CY18[1]		FY18/CY19[1]		FY19/CY20[1]	
		PMI	Global Fund	PMI	Global Fund	PMI	Global Fund
	Cross-Cutting Human Resources for Health**	-	$2.6M	-	$3.6M	-	$3.6M
	Central and Regional Program management[6]	$0.2M	-	$0.3M	-	$0.2M	-
	In-Country Staffing and Administration*	$1.2M	-	$2.2M	-	$1.7M	-
	Other Program Management**	-	$1.4M	-	$2.2M	-	$1.9M
	SBC Unspecified[5]	$0.5M	-	$0.4M	-	$0.7M	-
Total		**$25.0M**	**$30.1M**	**$25.0M**	**$48.5M**	**$23.0M**	**$29.6M**

Footnotes:

1. Each year's figures represent the FY for PMI and CY for Global Fund that most closely align. Global Fund budget data accurate as of July 1, 2019. PMI budget data accurate as of Sept 1, 2019;
2. Drug-based prevention, including SMC and MIP where relevant;
3. Covers management of in-country warehousing & distribution of malaria commodities, except for ITNs which are separately captured under "Vector Control";
4. May include cost of IRS insecticides if full cost of IRS implementation including commodities was bundled within a single line in prior year's Table 2;
5. SBC was not historically split in the PMI budget across intervention areas, hence the row “SBC (unspecified)” for the FY2020 MOP cycle. Going forward, SBC proposed activities will be categorized across vector control, case management, and prevention (new categories).
6. PMI Proposed Activity "National-level support for case management" rolls up under "Case Management" Level 1

Note: Categories shown reflect the harmonized financial taxonomy (Levels 1-3) developed by BMGF, Global Fund, and PMI in 2019, as part of a broader data harmonization initiative; potential for categories to continue to evolve through FY 2020 MOP process, as well as for additional donors and host country governments to adopt and reflect funding using same categories.

* Category currently funded by PMI only

** Category currently funded by Global Fund only

Figure 12. Annual Budget, Breakdown by Commodity

Year[1]	Funder	ITNs for Continuous Distribution	ITNs for Mass Distribution	IRS Insecticide[4]	ACTs	RDTs	Severe Malaria	SMC-Related	IPTp-Related	Total
FY17/CY18	PMI[2]	$0.2M	-	-	$6.3M	$4.2M	$1.2M	$0.9M	$0.1M	**$12.9M**
	Global Fund[3]	-	$14.6M	-	$1.0M	$0.9M	$2.9M	$0.7M	-	**$20.3M**
	Host Gov[5]	-	-	-	-	-	-	-	-	**-**
	Other[6]	-	-	-	-	-	-	-	-	**-**
	Total	**$0.2M**	**$14.6M**	**-**	**$7.3M**	**$5.2M**	**$4.2M**	**$1.6M**	**-**	**$33.1M**

Year[1]	Funder	ITNs for Continuous Distribution	ITNs for Mass Distribution	IRS Insecticide[4]	ACTs	RDTs	Severe Malaria	SMC-Related	IPTp-Related	Total
FY18/CY19	PMI[2]	-	-	-	$5.4M	$3.6M	$1.5M	$1.2M	-	**$11.7M**
	Global Fund[3]	-	$13.1M	-	$1.9M	$0.9M	$0.0M	$2.8M	-	**$18.7M**
	Host Gov[5]	-	-	-	-	-	-	-	-	**-**
	Other[6]	-	-	-	-	-	-	-	-	**-**
	Total	**-**	**$13.1M**	**-**	**$7.2M**	**$4.5M**	**$1.5M**	**$4.0M**		**$30.4M**
FY19/CY20	PMI[2]	-	-	-	$4.9M	$4.0M	$2.2M	$1.3M	-	**$12.3M**
	Global Fund[3]	$2.3M	-	-	-	$1.1M	-	$0.8M	-	**$4.3M**
	Total	**$2.3M**	**-**	**-**	**$4.9M**	**$5.1M**	**$2.2M**	**$2.1M**	**-**	**$16.6M**

Footnotes:

1. Each year's figures represent the FY for PMI and CY for Global Fund that most closely align. Global Fund budget data accurate as of July 1, 2019. PMI budget data accurate as of Sept 1, 2019 ;
2. PMI commodity costs are fully loaded, including costs for the ex-works price of the commodity, quality control, freight, insurance, and customs.
3. Global Fund commodity costs in table above only include ex-works commodity value in a given year. Additional costs, including quality control, freight, insurance, and customs totaled $11.3 million over the CY 2018-2020 period;
4. IRS insecticide; for PMI, IRS insecticide commodity costs may be inextricable from IRS implementation costs in historical data – field left blank where this is the case.

Note: Categories shown reflect the harmonized financial taxonomy (Levels 1-3) developed by BMGF, Global Fund, and PMI in 2019, as part of a broader data harmonization initiative; potential for categories to continue to evolve through FY 2020 MOP process, as well as for additional donors and host country governments to adopt and reflect funding using same categories.

V. ACTIVITIES TO BE SUPPORTED WITH FY 2020 FUNDING

Please see the FY 2020 budget tables (Tables 1 and 2) for a detailed list of activities PMI proposes to support in Burkina Faso with FY 2020 funding. Please refer to www.pmi.gov/resource-library/mops for the latest tables. Key data used for decision-making can be found in Annex A.

ANNEX A: INTERVENTION-SPECIFIC DATA

1. VECTOR CONTROL

NMCP objective
Malaria vector control is one of three major prevention interventions within the NMCP's strategic approach to protect individuals against infective malaria mosquito bites and to reduce the intensity of malaria transmission at the community level. Key vector control interventions in the NMCP's strategic plan include universal ITN coverage, IRS in selected high burden districts, and larval source control including environmental management.
NMCP approach
● Burkina Faso's goal of universal ITN coverage is defined as one ITN per two people. ITNs are distributed via mass campaigns every three years, in addition to routine distribution via ANC and EPI channels. ● The ITN strategy includes the deployment of standard, PBO, and IG2 ITNs, and all three types of ITNs were distributed in the 2019 mass campaign. ● IRS was re-initiated in Burkina Faso in 2018, and is deployed in addition to ITNs in high burden districts. Districts were selected with collaborative malaria stakeholders' meetings involving the NMCP, PMI, local research institutions and malaria partners.
PMI objective, in support of NMCP
PMI supports the NMCP's goal of universal ITN coverage and IRS campaigns in high burden districts.
PMI-supported recent progress (past ~12-18 months)
● PMI supported the 2019 mass ITN distribution campaign by procuring 120,000 standard ITNs and by providing technical assistance for the campaign. ● In 2019, PMI supported the implementation of IRS in the three high burden districts (one representing each of the malaria risk strata) of Kampti (Sud Ouest region, year-round transmission stratum), Koungoussi (Centre Nord region, short seasonal transmission stratum) and Solenzo (Boucle du Mouhoun region, long seasonal transmission stratum). A total of 201,901 structures were sprayed, protecting a population of 587,248. The key challenge to the IRS campaign was the insecurity in the country. ● PMI also supported entomological monitoring across 21 sentinel sites, including residual efficacy of IRS and insecticide resistance monitoring. However, in 2019, they were only able to cover 18 sites due to security issues.

PMI-supported planned activities (next ~12-18 months, supported by currently available funds)
● PMI will continue to support the routine entomological monitoring, and will also conduct durability monitoring activities to monitor the three types of ITNs distributed in the 2019 campaign. ● PMI will support the routine distribution of standard ITNs via EPI and ANC channels, and will procure routine ITNs with FY2020 funds. ● PMI will cease funding IRS in all three districts in FY2020 due to the high malaria burden nationwide and severe budget constraints. PMI will strive to lessen the impact of the withdrawal of IRS from the districts by working with the NMCP to ensure sensitization of populations, availability of effective ITNs (based on local resistance profiles) prior to the rainy season, reinforcement of proper ITN usage and high uptake of SMC. Additionally, PMI will support the districts to monitor supply chain levels and malaria cases, in order to quickly investigate and respond to increases in cases.

1.A. ENTOMOLOGICAL MONITORING

Key Goal
Determine the geographic distribution, bionomics, and insecticide resistance profiles of the main malaria vectors in the country to inform vector control decision-making

Do you propose expanding, contracting, or changing any entomological monitoring activities? If so, why, and what data did you use to arrive at that conclusion?
PMI will continue to support entomological monitoring including insecticide resistance monitoring in 21 sites and monthly bionomics monitoring in six of those sites. Three additional sites will conduct insecticide resistance monitoring via research institutions with other funding . Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Key Question 1

Where is entomological monitoring taking place, what types of activities are occurring, and what is the source of funding?

Supporting Data

Figure A1. Entomological Monitoring Sites

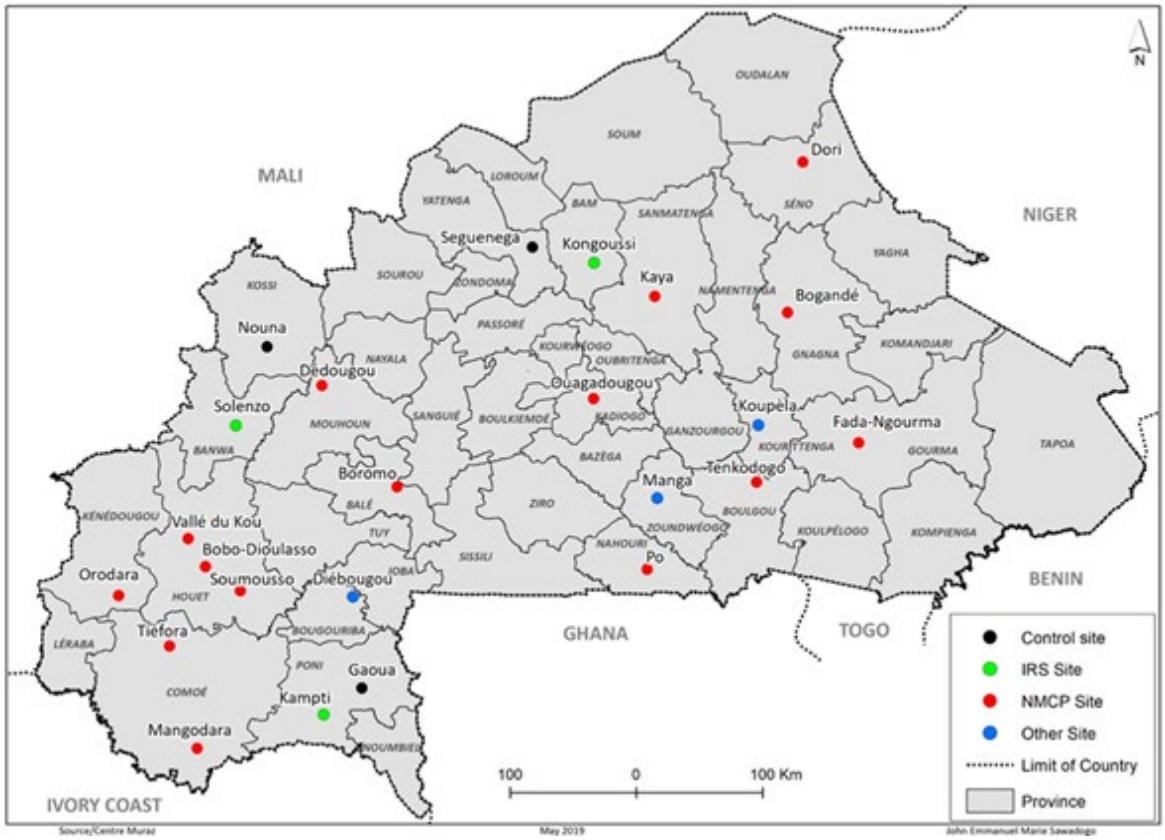


Figure A2. Entomological Monitoring Sites and Assays Conducted at Those Sites

District	Sentinel sites	Activities	Supported by
Poni	Kampti Gaoua	Cone Bioassays, HLC, PSC, IRM HLC, PSC, IRM	PMI
Banwa	Solenzo	Cone Bioassay, HLC, PSC, IRM	PMI
Kossi	Nouna	HLC, PSC, IRM	PMI
Bam	Kongoussi	Cone Bioassays, HLC, PSC, IRM	PMI
Yatenga	Seguenega	HLC, PSC, IRM	PMI
Comoe	Mangodara	IRM IRM	PMI CNRFP
Houet	Soumousso Valle du Kou Bobo-Dioulasso	IRM	PMI
Kourttenga	Koupela	IRM	PMI
Sanmatenga	Kaya	IRM	PMI
Seno	Dori	IRM	PMI
Gourma	Fada N'Gourma	IRM	PMI

District	Sentinel sites	Activities	Supported by
Boulgou	Tenkodogo	IRM	PMI
Bale	Boromo	IRM	PMI
Nahouri	Po	IRM	PMI
Bougouriba	Diebougou	IRM	PMI
Kenedougou	Orodara	IRM	PMI
Mouhoun	Dedougou	IRM	PMI
Kadiogo	Ouagadougou	IRM	PMI
Gnagna	Bogande	IRM	CNRFP
Zoundwepgo	Manga	IRM	CNRFP

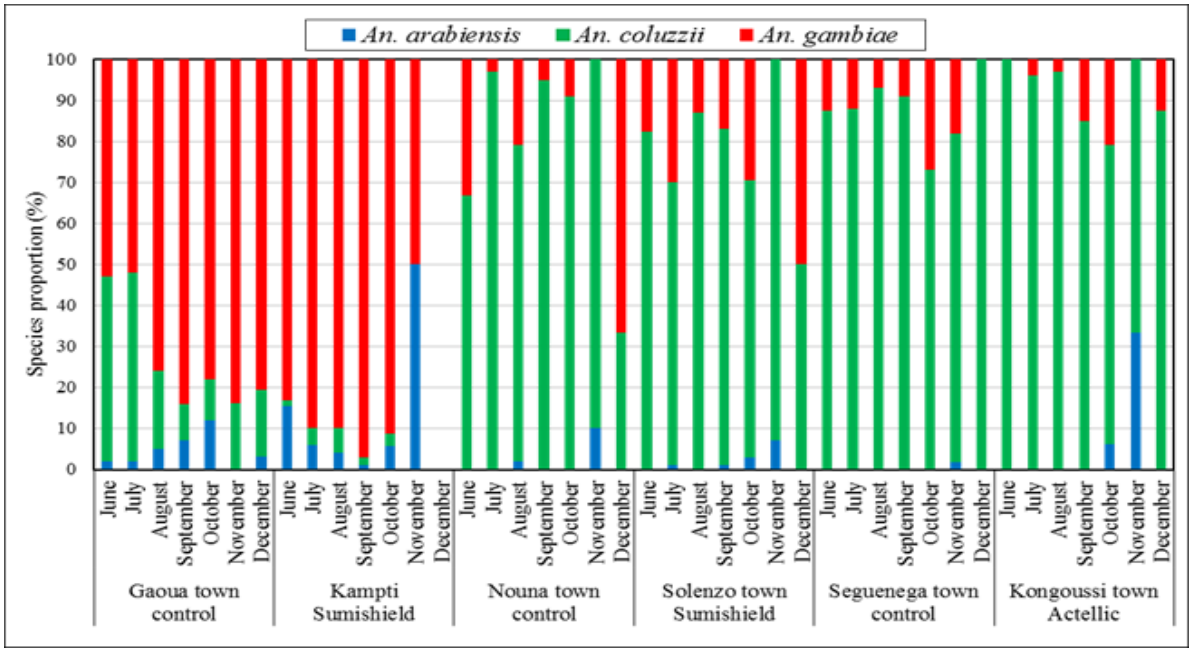
Figure A3. Bionomics Data from the Sprayed and Unsprayed Control Monitoring Sites

Site	Major Vector	Minor Vector	Peak Abundance	Preferred Biting Location	Preferred Host	Peak Sporozoite Rate	Annual* EIR
Gaoua	*An. gambiae*	*An. nili*	September	ncd	human	18%	293
Kampti	*An. gambaie*	*An. arabiensis*	September	ncd	human	18%	51
Nouna	*An. coluzzii*	*An. gambiae*	September	ncd	human	15%	70
Solenzo	*An. coluzzii*	*An. gambiae*	September	ncd	animal>human	7.7%	83
Seguenega	*An. coluzzii*	*An. gambiae*	September	ncd	human	10%	178
Kongoussi	*An. coluzzii*	*An. gambiae*	September	ncd	human	9%	75

ncd= no clear difference, biting occurred both indoors and outdoors

* estimate the sum of 7 months of collections

Figure A4. Species Composition of the Members of the *Anopheles gambiae* Complex (identified by PCR) Collected by HLC in the Sprayed and unsprayed Control sites (n=100 per month/site except in June)



More data may be found in the PMI VectorLink Burkina Faso Entomology Final Report January-December 2018.

Conclusion

- Entomological monitoring takes place in 21 sites. In six of those sites, monthly vector bionomics monitoring is conducted for seven months from June to December. In the other sites, the vectors are monitored for insecticide resistance (Figure A1 and A2). Although IRS will not be funded in FY2020, entomological monitoring will continue to be supported at sites in the current IRS districts (Kampti in the Sud Ouest, Solenzo in the Boucle du Mouhoun and Kongoussi in the Centre Nord).
- *Anopheles coluzzii* is the most abundant vector in the western part of the country but in the south *Anopheles gambiae* s.s. predominates (Figure A3). Nevertheless, vector composition varies throughout the time of the year (Figure A4).
- Mosquito abundance is generally highest in September (Figure A3). There was no clear preference in feeding location (indoor versus outdoor) and it varied by month. The preferred host in most cases were humans, except in Solenzo. Sporozoites were detected in all sites and entomological inoculation rates (EIR) were high throughout the country but were much lower in two of the sprayed sites than in their comparison unsprayed areas (Figure A3) and in addition, in general, they were higher in 2017.

Key Question 2

What is the current insecticide resistance profile of the primary malaria vectors?

Supporting Data

Figure A5: Susceptibility Tests of *Anopheles gambiae* s.l. against A) permethrin 0.75%, B) bendiocarb 0.1%, and C) Pirimiphos-methyl 0.25%, Performed Nationwide

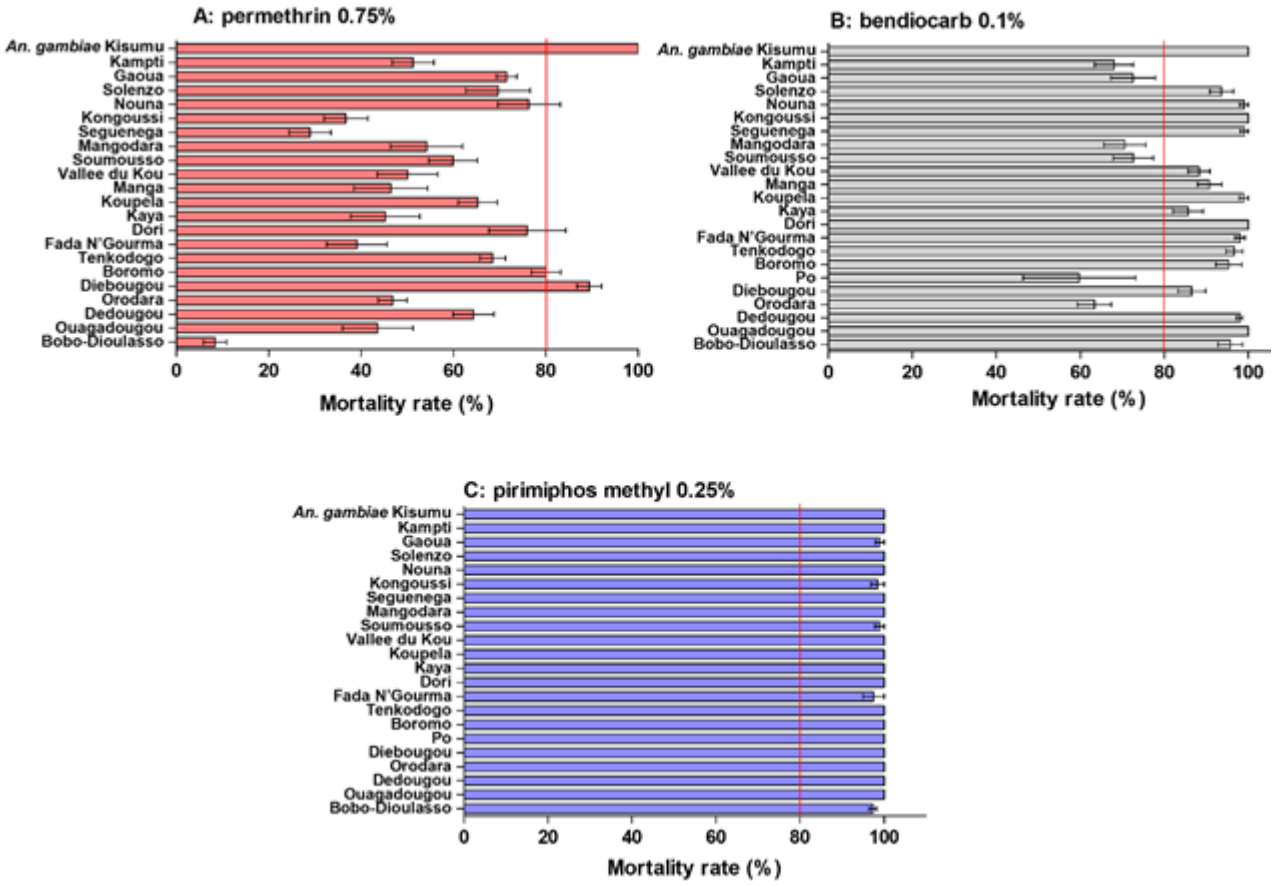
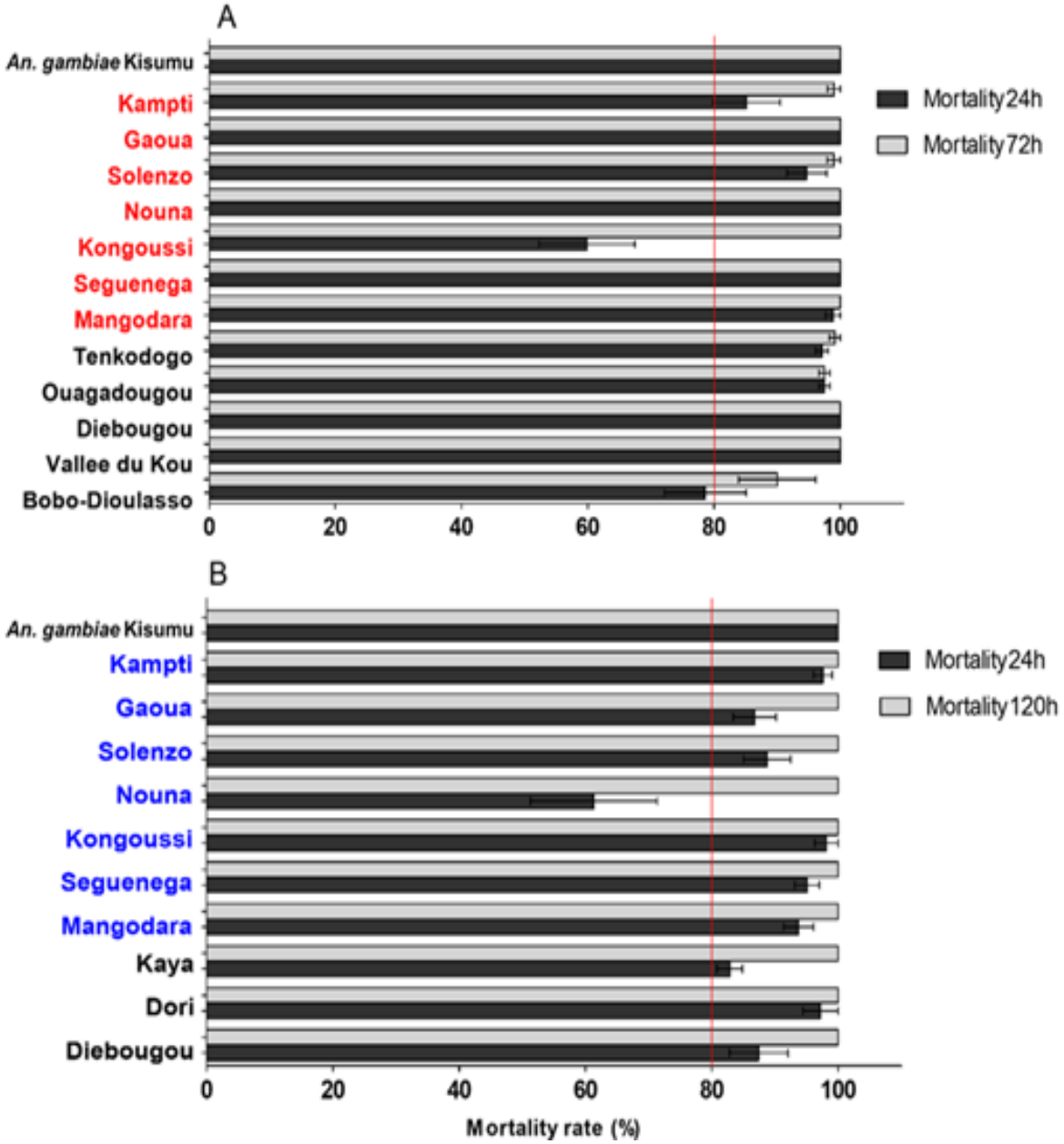
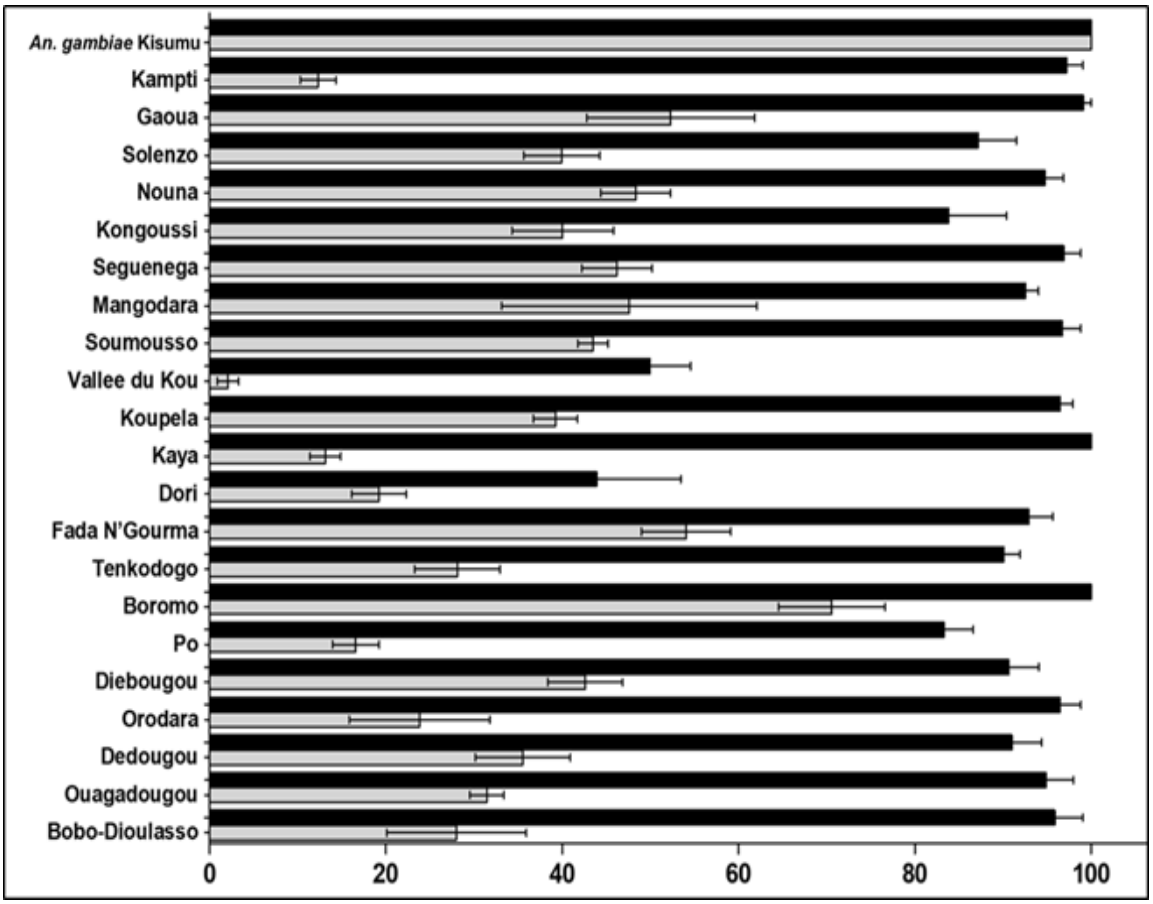


Figure A6: Susceptibility Tests of Wild *An. gambiae* s.l. to (A) Chlorfenapyr 100ug/bottle (250ml) and (B) Clothianidin 2%



Red and Blue refer to PMI IRS and control sites (plus Mangodara), respectively for chlorfenapyr and clothianidin testing; Black for other sites where the tests were completed.

Figure A7. Susceptibility Tests of *Anopheles gambiae* s.l.



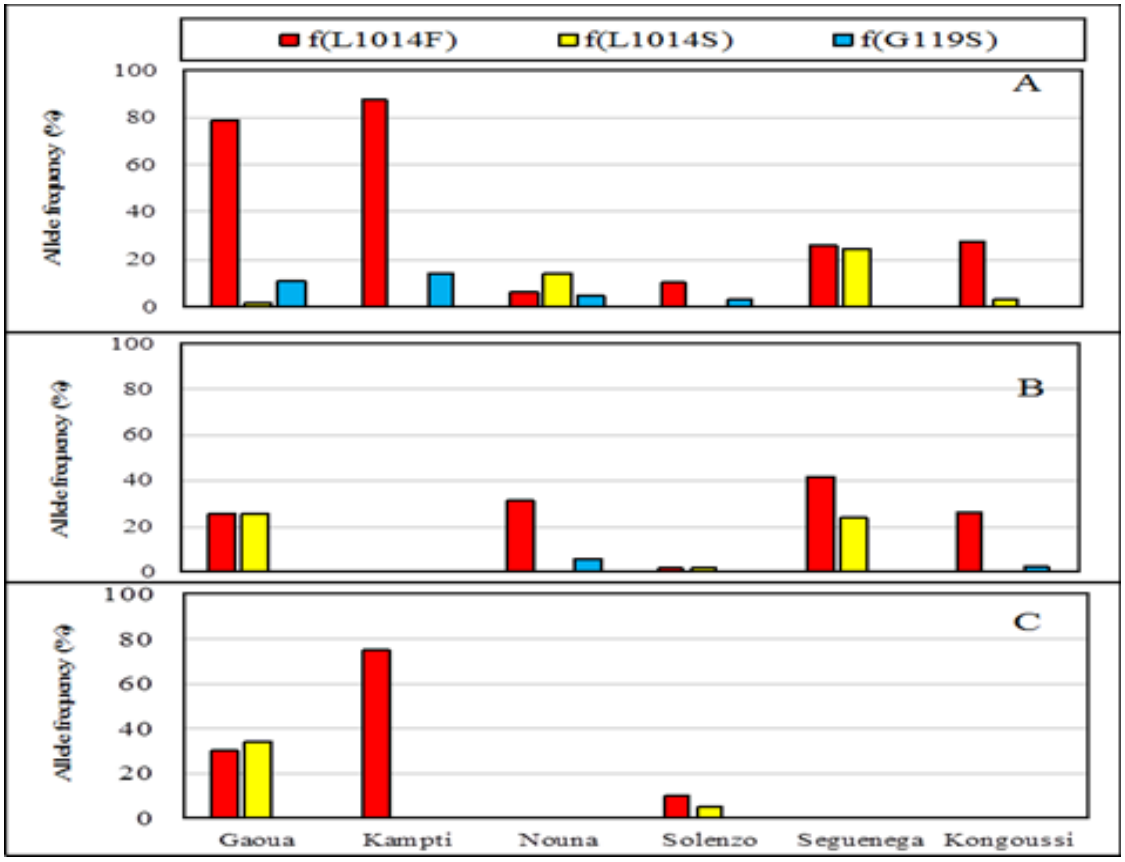
Deltamethrin 0.05% (grey bar); PBO 4% + deltamethrin 0.05% (black bar)

Figure A8. Mortality of *An. gambiae* s.l. after 24h Exposure to 1x, 2x, 5x Concentrations of Deltamethrin in CDC Bottle Bioassays and Associated Resistance Intensity, Based on WHO Classifications

Sites	Deltamethrin diagnostic concentration (%)						Status
	1x (0.05)		2x (0.1)		5x (0.25)		
	n	% Mortality [IC]	n	% Mortality [IC]	n	% Mortality [IC]	
Kampti	48	100	48	100	NA		Low resistance intensity/no resistance
Gaoua	44	100	47	100	NA		
Mangodara	61	100	59	100	NA		
Bobo-Dioulasso	44	100	52	100	NA		
Nouna	47	100	57	100	NA		
Ouagadougou	59	94.02 [66.95-121]	62	98.48 [79.23-117]	61	100	
Solenzo	47	78.57 [33.19-124]	49	85.53 [7.68-163]	50	100	
Kougoussi	47	98.00 [72.59-123]	49	98.07 [73.64-122]	49	100	
Seguenega	47	83.97 [75.83-92]	49	87.54 [70.51-104]	44	95.65 [95.65-123]	*100% KD at 120mn*

NA (Not applicable): 98–100% mortality at 2x dose indicates a low resistance intensity. Not necessary to assay at 5x dose.

Figure A9. Summary Allele Frequencies of kdr (L1014 & 1041S) and Ace-1R within (A) *An. gambiae*, (B) *An. coluzzii* and (C) *An. arabiensis* Populations from Intervention and Control Sites



Conclusion

- Insecticide resistance is widespread throughout the country. The susceptibility of mosquito populations to permethrin was less than 80 percent in all sites tested except one. Mosquito populations were still susceptible to bendiocarb in most sites; in only six sites was it less than 80 percent (Figure A5).
- Susceptibility to Pirimiphos-methyl was still above 98 percent in all sites tested and therefore it remains a viable insecticide for IRS (Figure A5.)
- Susceptibility to the new insecticides (the pyrrole chlorfenapyr and the neonicotinoid clothianidin) was 98-100 percent in all sites tested except for Bobo-Dioulasso where the susceptibility was less than 95 percent for chlorfenapyr (Figure A6). Formulations using these insecticides should be effective against mosquito populations in Burkina Faso.
- Pre-exposure to PBO restored susceptibility to deltamethrin to some mosquitoes in all populations tested. PBO pre-exposure increased the percentage of susceptible mosquitoes to greater than 80 percent in 19 of 21 sites. In the other two sites, the increase was 20-40 percent. These data suggest that esterases are involved in resistance and that PBO nets may be more protective than that standard ITNs in Burkina Faso(Figure A7).

- The intensity of resistance to deltamethrin was below 5x in all areas tested meaning that none of the mosquitoes survived the 5x dose of insecticide. These data suggest that although resistance was detected, it is less likely to lead to control failure.
- Molecular analyses of the sodium channel gene showed that the common mutation associated with pyrethroid resistance *L1014F (kdr-west)* was detected in mosquitoes in all six sites where tested. In Gaoua and Kampti, more than 80 percent of the *An. gambiae* s.s. possessed this allele. The *L1014S (kdr-east)* allele was detected in at least one of the members of An. gambiae complex in all sites tested. The *Ace-1R (G119S)* mutation in the acetylcholinesterase gene, the target of organophosphate and carbamate insecticides was found in five of the six study sites.

Insecticide resistance is widespread in Burkina Faso, but new insecticides and combinations with the synergist PBO are effective against these mosquitoes. Continued entomological surveillance is needed to detect resistance problems and allow for the rotation of vector control interventions as needed.

Key Question 3

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

None

Conclusion

N/A

1.B. INSECTICIDE-TREATED NETS (ITNs)

PMI Goal
Achieve high ITN coverage and usage of effective nets in endemic PMI-supported areas (in the context of the current insecticide resistance); and maintain high coverage and use with consistent ITN distribution (via campaigns and/or continuous channels in a combination that is most effective given country context).

Do you propose expanding, contracting, or changing any ITN activities? If so, why, and what data did you use to arrive at that conclusion?
● With FY2019 funds, PMI is providing funds to support durability monitoring of nets distributed during the 2019 campaign including the standard, next generation and PBO nets. This monitoring will provide data on: ○ net survivorship and physical integrity, ○ bio-efficacy of insecticides, and

- insecticide content.

- With FY2020 funds PMI will support continued durability monitoring of these nets. While there is likely a minimal gap of PBO and IG2 ITNs in 2020 and 2021, there is an estimated gap of 1.8 million standard nets needed for the routine distribution system. PMI will also purchase approximately 500,000 standard nets to help reduce this gap.

Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

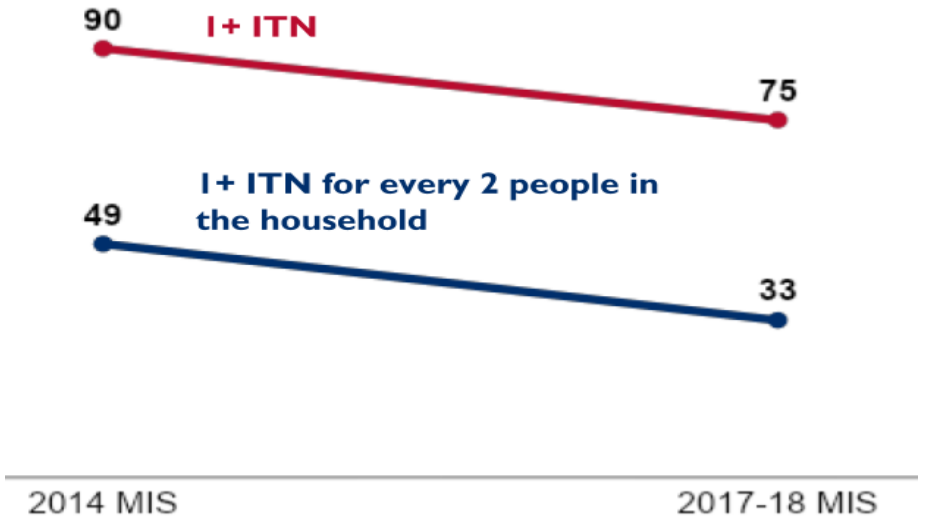
Key Question 1

How has net ownership evolved since the start of PMI in the country? Are households fully covered?

Supporting Data

Figure A10. Trends in ITN Ownership

Percent of households



Conclusion

Although the data indicate a decrease in net ownership, the most recent MIS was conducted two years after the mass campaign during the dry season. Burkina Faso had a mass distribution campaign in 2019 and distributed approximately 12.8 million nets. Therefore, the last coverage estimates are not a true reflection of current rates. The next nationwide household survey is the DHS and is scheduled to take place in 2020 and includes assessment of all key malaria indicators. Particular emphasis has been made to ensure that malaria indicators are measured during the high transmission season. ITN indicators would be revisited once results of the 2020 DHS are available.

Key Question 2

What proportion of the population has access to an ITN? In contrast, what proportion of the population reports using an ITN? What is the ratio between access and use? Does it vary geographically?

Supporting Data

Figure A11. Trends in ITN Access and Use

Percent of household population with access to an ITN and who slept under an ITN the night before the survey

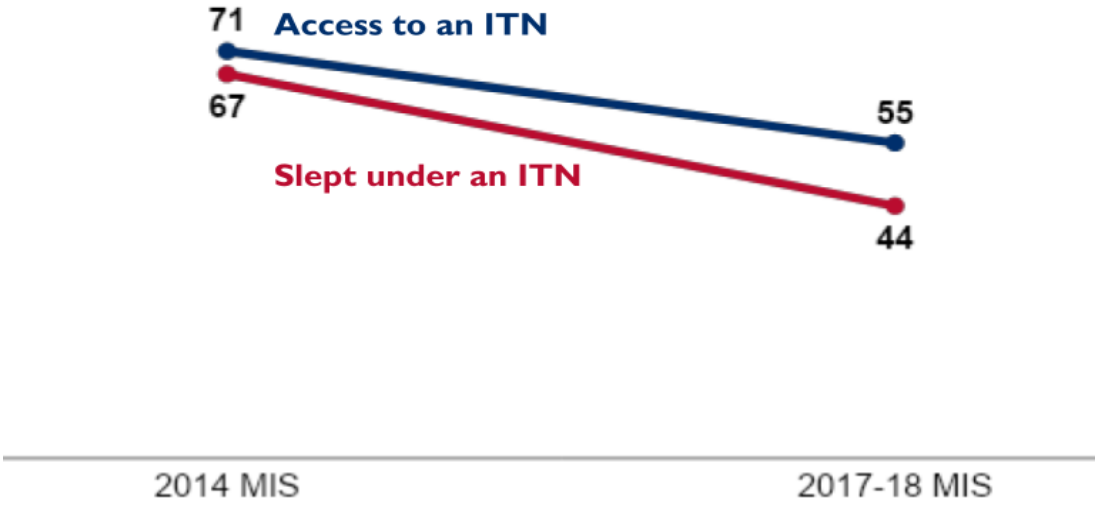
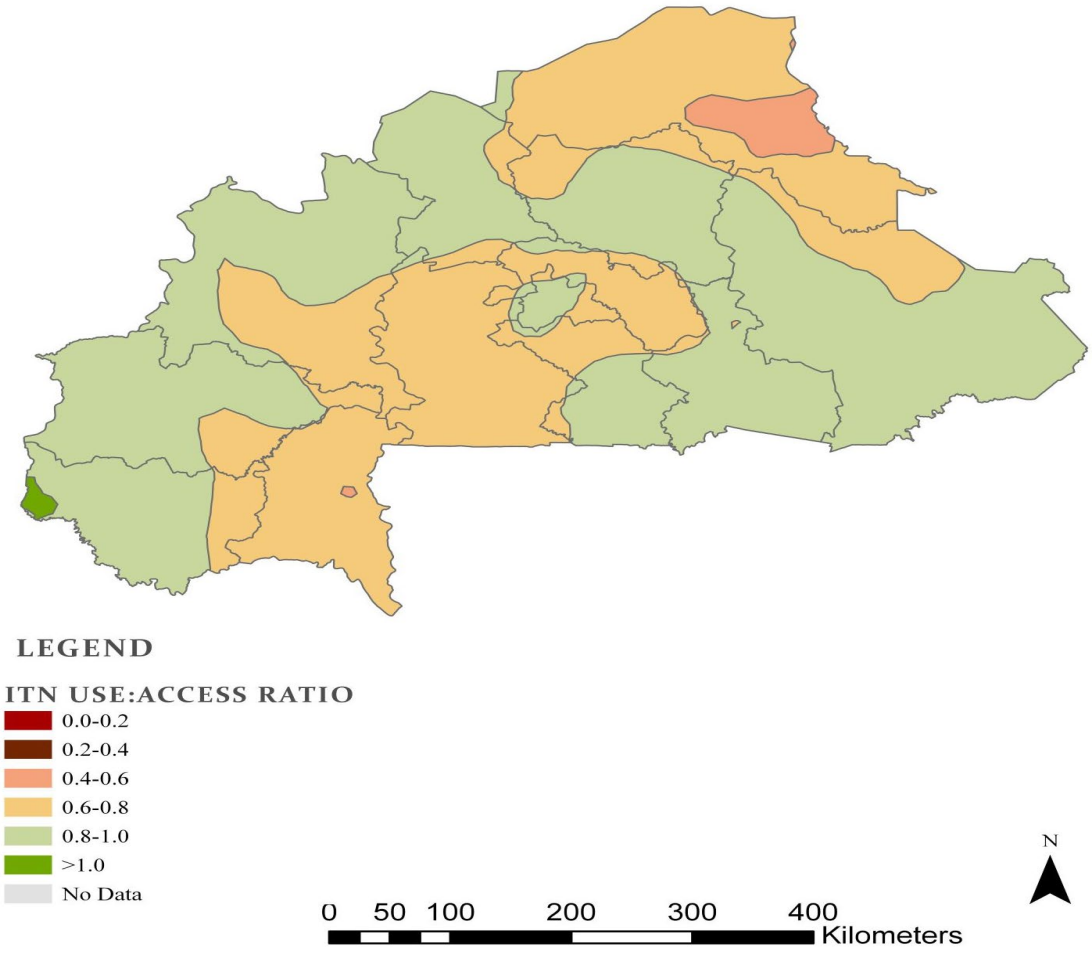


Figure A12. ITN Use: Access Ratio in Burkina Faso



Source: MIS 2017

Conclusion

Net use appears to be directly related to availability of nets. Although there is some variation between access and use throughout the country, the numbers are relatively the same. The one area where use and access were particularly low is also an area with security issues.

Key Question 3

In areas where ITN access is high but use is low, what is known about the key barriers and facilitators to use?

Supporting Data

Figure A13. Key Barriers and Facilitators to ITN Use

Facilitator	Type of Factor	Data Source	Evidence
Household availability of ITNs	Environmental	MIS 2017-2018 (Breakthrough Action Observations of MIS)	Use by children and women is prioritized when insufficient nets are available in the household. Youths and men use the nets the least but groups level out when sufficient nets are available in households
Knowledge of ITNs use	Internal	NMCP	Generally high knowledge of ITN use among population
Barrier	**Type of Factor**	**Data Source**	**Evidence**
Low perceived risk during dry season	Internal	NMCP (unpublished reports from supervision visits)	Low ITN use observed during the hot season, when sleeping outdoors occurs
Insufficient ITNs	Environmental	NMCP	During/after the 2019 mass ITN distribution campaign, it was clear that the amount of ITNs procured would not fully cover the population. The ITN procurement was placed before the population census occurred; additionally, the internal population migration due to security posed challenges with ensuring ITNs reached all populations.

Conclusion

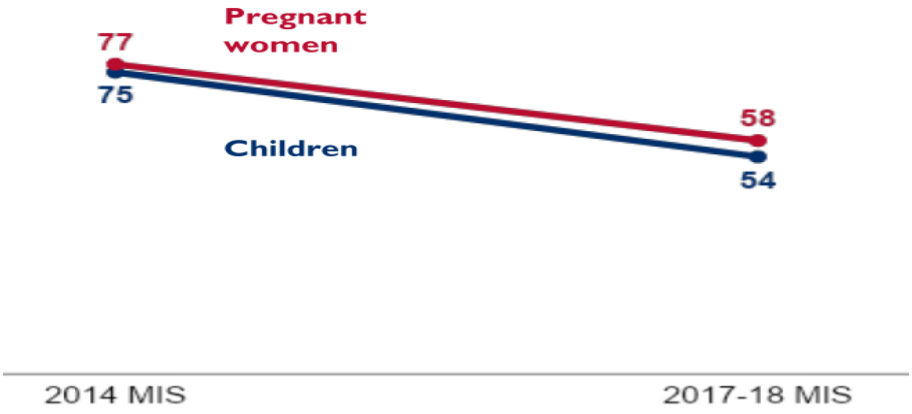
Based on the 2017-2018 MIS, ITN access is fairly uniform throughout the country but not particularly high. However, there was a national ITN mass distribution campaign in 2019, the year after this MIS (which took place during the low-transmission season) was completed and therefore access is expected to improve. Nevertheless, there appears to be a high correlation between access and use, but use is more important during periods of high transmission. If there are not sufficient nets in a household, women and children are prioritized. Use is similar among age groups when sufficient nets are available. Ensuring sufficient nets are available through multiple channels as well as SBC for promotion of use throughout the year is needed.

Key Question 4

What percent of pregnant women and children under 5 report sleeping under an ITN?

Supporting Data

Figure A14. Trends in ITN Use among Children and Pregnant Women



Conclusion

According to MIS data, ITN use among children and pregnant women declined between 2014 and 2017-2018. However, there was an ITN distribution campaign in 2019, the year after this MIS (which took place during the low-transmission season) was completed. This graph is probably not a good reflection of the current situation. Nevertheless, evidence suggests that if insufficient nets are available, net use is prioritized for children under 5 years of age and women of reproductive age.

Key Question 5

What channels are used to distribute ITNs?

Supporting Data

Figure A15. ITN Distribution Channels, 2015 - 2021

Channel	2015	2016	2017	2018	2019	2020	2021
EPI	X	X	X	X	X	X	X
ANC	X	X	X	X	X	X	X
Schools							
Community							
Mass Campaign		11 million			12.8 million		

Conclusion

Burkina Faso uses two systems to distribute nets: (1) mass campaigns and (2) continuous distribution through ANC and EPI. The country has seen four mass campaigns in the last 12 years with the last one occurring in 2019. As for the continuous distribution system, PMI-funded

an assessment of this system in 2018. Although the key components of the continuous distribution system are in place, there are some significant challenges. Around 78 percent of women received ITNs during their first ANC visit, but only 25 percent of expected children received a net during the EPI visit. The major problems identified include:

- reduced frequency of necessary coordination meetings and supervision visits
- limited knowledge of how to use the tools for the health commodity pull system that determine the health center commodity resupply based on their monthly reporting of consumption and stock levels
- insufficient funds to ensure "last kilometer" of LLIN availability at the health center
- oversupply in some districts and problematic storage conditions for larger quantities of LLINs
- data inconsistencies.

The report suggests that Burkina Faso consider exploring additional distribution channels such as school-based, or community-based continuous distribution channels.

Key Question 6

What was the estimated need for ITNs during calendar year 2019? What are the estimated ITN needs over calendar years 2020 and 2021? What volume of ITNs are available from partners and the public sector for the next three calendar years?

Supporting Data

Figure A16. Gap Analysis of ITN Needs

Calendar Year	2019	2020	2021
Total Targeted Population [1]	20,870,060	21,478,529	22,144,363
Continuous Distribution Needs			
Channel #1: ANC (FE) ITNs [2]	929,785	930,436	931,087
Channel #2: EPI (Enfant) ITNs [3]	850,328	860,641	871,078
Estimated total consumption	1,780,113	1,791,077	1,802,165
Estimated Total Need for Continuous Channels **(including 3 months buffer stock)[4]**	1,780,113	2,238,846	2,252,706
Mass Campaign Distribution Needs			
2019/2020/2021 mass distribution campaign(s)			
Estimated Total Need for Campaigns	0	0	0
Total ITN Need: Routine and Campaign	**1,780,113**	**2,238,846**	**2,252,706**
Partner Contributions			
ITNs carried over from previous year	1,414,003	443,347	0
ITNs from MOH	0	0	0

Calendar Year	2019	2020	2021
ITNs from Global Fund	802,308	889,620	
ITNs from other donors	0	0	
ITNs planned with PMI funding	7,149	0	500,000
Total ITNs Available	**2,223,460**	**1,332,967**	**500,000**
Total ITN Surplus (Gap)	**443,347**	**-905,879**	**-1,752,706**

Footnotes:

[1.] Total Targeted Population: Demographic Projections -INSD (*Institut National de la Statistique et de la Démographie*) 2011-2020 and 2021 with Population Growth Rate of 3.1%.

[2.] ANC-ITNs: The forecast of ITNs for Pregnant Women attending ANC is based on the Number of women received at the health facilities for ANC1 from HMIS database. From years 2017 to 2018 and from 2018 to 2019 (estimated), the percentage increase in number of women attended ANC1 were 0.203% and 0.352%, respectively. For 2020 and 2021 the quantification committee members agreed to use the average increase of 0.07% from 2017 to 2018 and from 2018 to 2019 (estimated). Three types of LLINs (Standard, PBO and IG 2) are distributed according to the zones. The proportions of the three ITNs are similar to that for EPI.

[3.] EPI-ITNs: The forecast of ITNs for children under one year old is based on the number of live births at the health facilities (from HMIS reports). The percentage increase in number of live births at the health facilities from years 2017 to 2018 and from 2018 to 2019 (estimated), were 1.21% and 6.82% respectively, with an average increase of 4.02%. But the quantification committee members agreed to maintain percentage increase between 2017 and 2018 which is 1.21% for the projection for 2020 and 2021. Since three types of ITNs are distributed through EPI channel for one year old children from 2019, the projection of the ITNs for 2020 and 2021 has also considered the three types of ITNs: 74.8% of total ITNs distributed through EPI in 2019 are standard ITN; 11.2% in PBO and 14.0% in IG2.

[4.] Since the ITN is bulky, the quantification committee decided to consider only three months buffer stock for 2020 and 2021 for total ITN needs for routine distribution. For 2021: Global Fund grant 2021-2023 is not yet developed, nor the FY20 MOP. So, the gaps remain in 2020 and 2021.

Figure A17. Additional data on ITN type

Net Type	2019 Mass Campaign (%)	Quantity Purchased for Routine
Standard LLIN	9,9774,530 (74.4)	1,511
PBO nets	1,432,685 (11.2)	334,415
IG2 nets	1,588,196 (12.4)	466,382
Total	12,795,411	802,308

Conclusion

Approximately 12.8 million nets were distributed during the mass campaign of 2019. GF purchased standard LLINs, IG2 and PBO nets for the campaign as well as sufficient PBO and IG2 nets to cover two years of ANC and EPI continuous distribution in the districts where these types nets were distributed. However, because the estimate of the number of nets needed for the campaign fell short of the actual needs, some of these IG2 and PBO destined for routine were used for the mass campaign. The IG2 and PBO nets did not arrive until October 2019 and thus the 1.4 million standard nets carried over from the previous year were used for the routine system all districts. In 2020 and 2021 PBO and IG2 ITNs will be distributed for ANC and EPI in the districts that received these net types in the mass campaign. Due to the very late arrival of the IG2 and PBO nets, the gap resulting from the underestimation was much smaller than it would have been if the nets arrived in May as originally planned (six months of needs for routine distribution were effectively eliminated and covered with standard nets). There is therefore likely

to be a minimal gap in IG2 and PBO nets for routine distribution in 2020 and 2021. However, it appears that there will be insufficient standard nets for distribution in the other districts in 2020 and 2021. PMI has agreed to purchase approximately 500,000 nets with FY2020 funds. The 2021-2023 GF grant has not yet been developed.

Key Question 7

What is the current status of durability monitoring?

Supporting Data

Figure A18. Current Durability Monitoring

Campaign Date	Sites	Brands	Baseline	12-month	24-month	36-month
2019	Banfora, Orodara, Gaoua	PermaNet 2.0, PermaNet 3.0, DuraNet, MagNet, Interceptor, Interceptor G2	Dec 2019	ND	ND	ND

ND=not done

Conclusion

Monitoring activities are just beginning and conclusions will be presented at the end of the monitoring activities in 2022.

Key Question 8

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

N/A

Conclusion

N/A

1.C. INDOOR RESIDUAL SPRAYING (IRS)

Key Goal
Ensure high spray coverage, with an appropriate insecticide, in targeted endemic PMI-supported areas.

Do you propose expanding, contracting, or changing any IRS activities? If so, why, and what data did you use to arrive at that conclusion?
PMI/Burkina Faso is unable to support IRS with FY 2020 funds due to severe budgetary constraints related to the extremely high burden of malaria, and the need to increase and/or maintain support for other interventions such as procurement of commodities. Therefore, Burkina Faso's IRS program will have to come to an end after three years of implementation (2018-2020). In anticipation of the

withdrawal of IRS in 2021, communities will be sensitized as to appropriate ITN use and care, and health districts will monitor malaria stocks and increases in cases.

Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Key Question 1

What areas are targeted for IRS and why?

Supporting Data

PMI is the only funder of IRS in Burkina Faso. PMI support for IRS implementation from 2018-2020 covers three districts: Kampti (Sud Ouest region, year-round transmission), Koungoussi (Centre Nord region, short seasonal transmission) and Solenzo (Boucle du Mouhoun region, long seasonal transmission). These three districts were selected through a collaborative, data-driven decision making process with key malaria stakeholders meetings including the NMCP, PMI, local research institutions and other malaria donors.

Conclusion

No IRS will be conducted with FY2020 funds.

Key Question 2

In PMI-supported areas, what spray coverage rates have been achieved in the past 5 years?

Supporting Data

Figure A19. PMI-Supported IRS Coverage

Calendar Year	Number of Districts Sprayed	District Names**	Number of Structures Sprayed	Coverage Rate	Population Protected
2018	3	Kampti, Kongoussi, Solenzo	258,766	97%	766,374
2019	3	Kampti, Kongoussi, Solenzo	201,901	92%	587,248
2020*	3	Kampti, Kongoussi, Solenzo	201,901	TBD	587,248

*Denotes targets **If more than 15 districts, list regions/provinces.

Conclusion

High coverage has been achieved in the three districts where PMI has supported IRS, however IRS will not be supported beyond 2020.

Key Question 3

What is the residual efficacy of the insecticides used for IRS in PMI-supported areas?

Supporting Data

Provide data on cone bioassay mortality derived from PMI spraying over time to demonstrate duration of IRS effectiveness.

Figure A20. IRS Effectiveness in PMI-Supported Areas, 2019

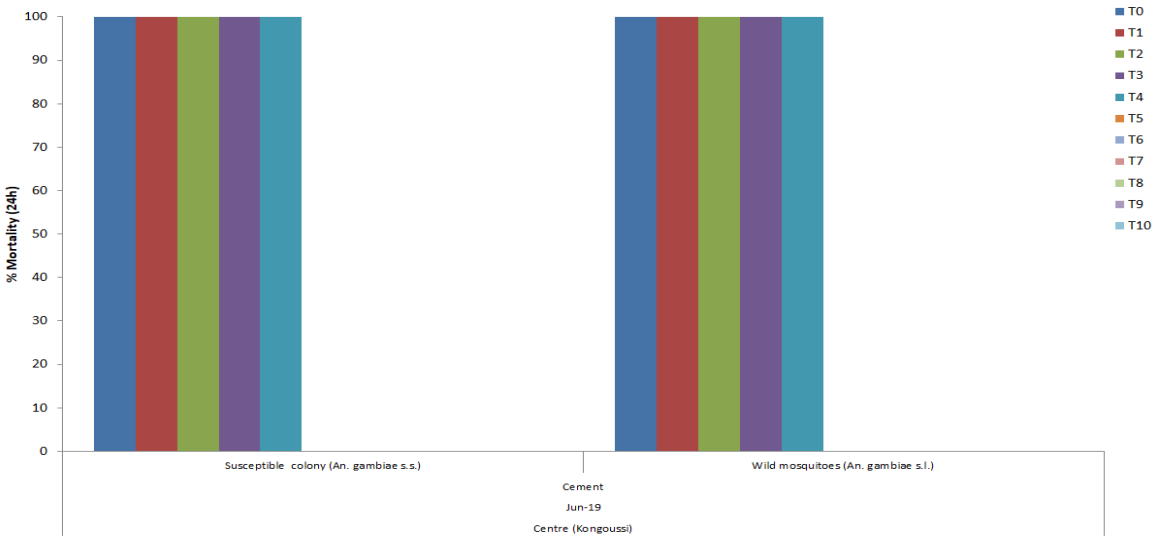
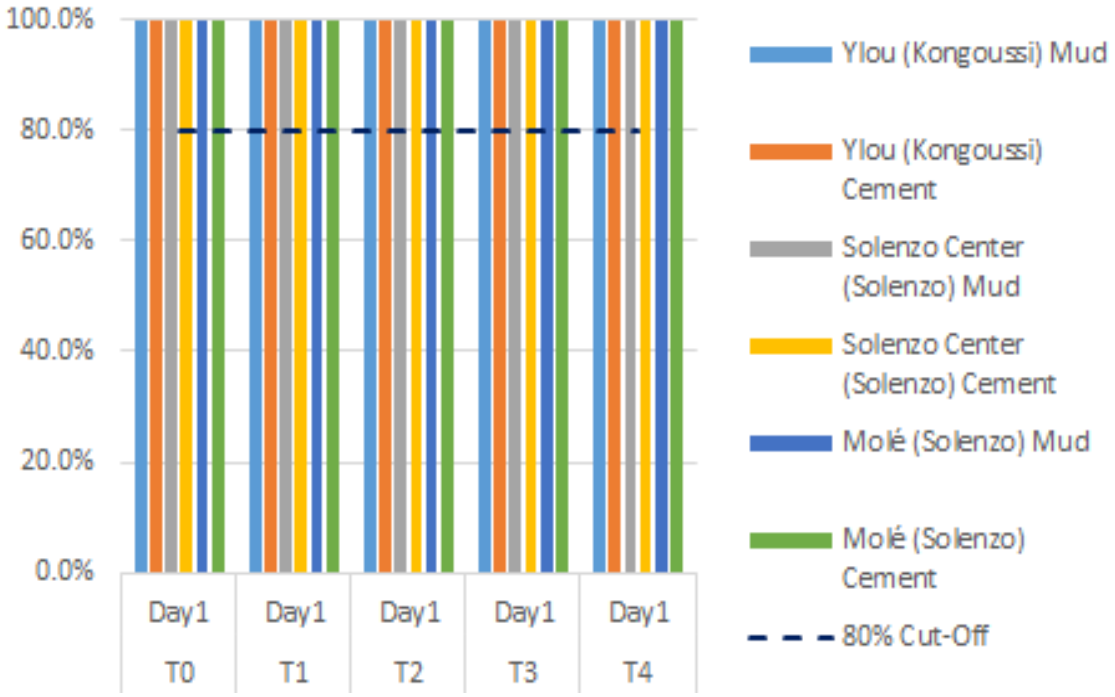


Figure A21. Burkina Faso SumiShield Residual Efficacy in Kisimu Colony



Conclusion

The data above from the 2019 IRS campaign (Figure A20) shows that the residual efficacy of Pirimiphos-methyl and clothianidin insecticide both continue to be high, with ~100 percent, five months after the IRS campaign took place. IRS completed in 2018 resulted with 9-10 months of residual efficacy for Pirimiphos-methyl and 10-11 months of residual efficacy for clothianidin, so the expectation is 2019 would have a similar impact.

Key Question 4

What is the plan for insecticide rotation? What insecticide will be used next in PMI-supported areas?

Supporting Data

Figure A22. Insecticide Rotation in PMI-Supported Areas

Year	Kampti	Kongoussi	Solenzo
2018	clothianidin (SS)	Pirimiphos-methyl	clothianidin (SS) & Pirimiphos-methyl
2019	clothianidin (FF)	clothianidin (SS) & Pirimiphos-methyl	clothianidin (SS)
2020*	clothianidin or Pirimiphos-methyl	clothianidin or Pirimiphos-methyl	clothianidin or Pirimiphos-methyl

*Denotes planned insecticide classes

Conclusion

Burkina Faso plans to continue to pre-emptively rotate insecticides for IRS, due to the high levels of insecticide resistance found in the country. Assuming that Pirimiphos-methyl continues to have high residual efficacy, then both Pirimiphos-methyl and clothianidin will be used in 2020.

Key Question 5

Are the NMCP and PMI considering withdrawing IRS from any PMI-supported? If so, what programs are in place to cover anticipated increases in malaria cases and promote consistent net use and care-seeking behaviors?

Supporting Data

Yes, PMI will cease IRS in all three districts with FY2020 funding, due to the high malaria burden nationwide and severe budget constraints. In order to lessen the impact of the IRS withdrawal from these districts, PMI will support the NMCP to ensure sensitization of populations, availability of effective ITNs (based on the local resistance profile) prior to the rainy season, reinforcement of proper ITN usage and high uptake of SMC. Additionally, PMI will support these districts to continue entomological monitoring as well as monitor supply chain levels and malaria cases, in order to quickly investigate and respond to increases in cases.

Conclusion

IRS will conclude in Burkina Faso, after implementation from 2018-2020.

Key Question 5

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

Due to the extremely high malaria burden in Burkina Faso, with around 12 million confirmed cases in 2018, plus the changing of first line malaria treatments, the PMI budget is insufficient to continue supporting IRS in three districts.

Conclusion

N/A

2. HUMAN HEALTH

2.A CASE MANAGEMENT in health facilities and communities

NMCP objective
Per the revised 2016-2020 NSP: **Facilities** ● 100 percent of suspected malaria cases receive a diagnostic test (RDT or microscopy) ● 100 percent of uncomplicated malaria cases diagnosed in a health facility receive treatment in line with the national case management guidelines ● 100 percent of severe malaria cases confirmed in health facilities receive treatment in line with the national case management guidelines **Communities** ● At least 80 percent of uncomplicated malaria cases confirmed by CHWs receive treatment in line with the case management guidelines within 24 hours ● At least 80 percent of the population knows three malaria symptoms and three prevention methods
NMCP approach
Diagnosis: Obligatory laboratory testing of suspect malaria cases is done either by microscopy or RDT. Microscopy is largely restricted to Burkina Faso's nine district hospitals and four university hospitals. The expansion of RDT testing to the community level was implemented in 2016.

Treatment: National treatment guidelines call for artemether-lumefantrine (AL), Dihydroartemisinin-Piperaquine (DP), or artesunate-amodiaquine (ASAQ) as first-line drugs for treatment of uncomplicated malaria. However, with large-scale expansion of SMC in 2017, recently modified NMCP guidelines phase out ASAQ by June of 2018.

Treatment of severe malaria is performed at the hospital and *Centre de santé et de la promotion social* (CSPS) level. The NMCP is currently piloting pre-referral rectal artesunate for children under five years of age by CHWs in three districts in North and Sahel regions, where malaria mortality is the highest. The first-line treatment for severe malaria in public health facilities is intravenous artesunate; in its absence, injectable quinine may be used. The NMCP recommends the use of intramuscular artemether in private health facilities capable of providing severe malaria treatment.

Training, supervision, and QA/QC: Doctors and nurses receive instruction on malaria case management during their regular pre-service training. Since the start of PMI in Burkina Faso, PMI funding has supported re-training and on-the-job supervision for malaria case management

Health workers at the CSPS level are supervised by district health authorities. In turn, the head nurse of each CSPS is tasked with the supervision of all the CHWs attached to his or her CSPS. Supervision of laboratory technicians (located in the district and reference hospitals) conducting malaria microscopy falls under the purview of the *Direction General de la Pharmacie, Médicine et Laboratoire* (DGPML).

Community case management: Training and supervising CHWs in malaria case management is part of the NMCP's strategy to improve nationwide diagnosis and treatment of malaria. There are two CHWs per village throughout Burkina Faso, and up to four in villages with more than 2,000 inhabitants. Integrated community case management occurs in villages that are further than 5km from the nearest health facility by 12 568 out of 17,668

CHWs in Burkina Faso. All CHWs are responsible for SBCC activities as well. The scale-up of malaria care delivery by CHWs was formalized by the nationwide identification and training of CHWs in integrated management of childhood illness in late 2016. National policy outlines a CHW incentive of 20,000 CFA (about $34) per month, in addition to compensation for training, vaccination campaigns, etc.

PMI objective, in support of NMCP

Along with other financial and technical partners, PMI contributes to nationwide implementation of Burkina Faso's case management strategy with the exception of contributing to the salaries of CHWs.

PMI-supported recent progress (past ~12-18 months)

Progress:

- Support to the pilot implementation of pre-referral treatment with rectal artesunate for children under five years of age in the Sahel region

- Training of 326 providers in 10 referral hospitals and 350 health center providers on malaria case management guidelines
- Support to the NMCP to implement mobile mentoring (mMentoring) for 800 providers in the Sahel region
- Implementation and dissemination of the results of a two-arm, three site antimalarial therapeutic efficacy study

Challenges and bottlenecks

- The security situation in Burkina Faso has directly impacted service delivery work due to the closure of health facilities in some insecure areas and inaccessibility of PMI partners in others. Strategies such as the mMentoring program, where healthcare workers are trained and given quizzes by mobile phones, will become increasingly valuable in these hard-to-reach areas.
- The health sector strike in 2019 impacted the ability to train health workers in some areas and access to any routine data from the health system to track progress using facility-based data.
- CHWs have not been paid since January 2019, impacting retention and ability to carry out routine activities, including data collection and entry into the national system.

PMI-supported planned activities (next ~12-18 months, supported by currently available funds)

- An evaluation of the pilot of pre-referral treatment with rectal artesunate in the Sahel region to facilitate decisions about expansion of the intervention
- Assistance to conduct a three-arm, three site TES including AL, DP, and artesunate-pyronaridine; two scientists from Burkina Faso will be trained to investigate evidence of antimalarial resistance through the PARMA network in Atlanta
- Revision of the recommended ACTs in the national case management guidelines considering the results of previous therapeutic efficacy studies
- Support for integrated supervision visits and in-service refresher training for health workers

PMI Goal

Improve access to and utilization of timely, quality, and well-documented malaria testing and treatment by providing facility- and community-based health workers with training, supervision, and malaria commodities to be able to provide high-quality, effective care.

Do you propose expanding, contracting, or changing any Case Management activities? If so, why, and what data did you use to arrive at that conclusion?
Case management activities will be based on the Burkina Faso Strategic Plan for 2021-2025, which is in the process of being developed. In FY 2020, PMI will provide support ($500,000) to the implementation of the community health strategy for malaria, including iCCM, data collection, and SBC. All PMI-supported strategies will be adapted to the security situation (e.g., where to target activities such as the mMentoring program). Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

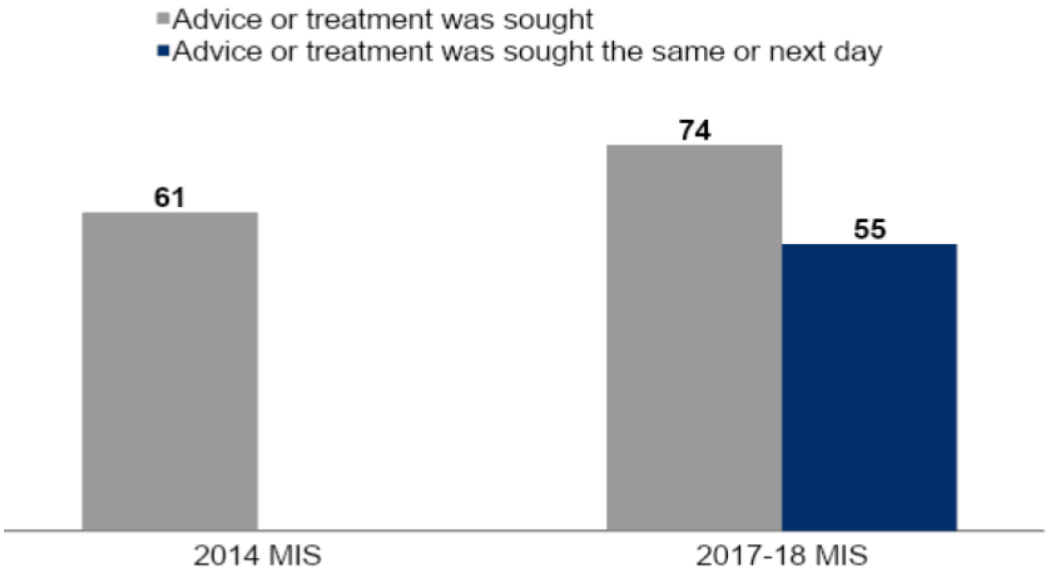
Key Question 1

What is the status of care-seeking?

Supporting Data

Figure A23. Trends in Care-Seeking for Fever

Among children under 5 with fever in the 2 weeks before the survey for whom:



*Excludes treatment or advice from a traditional practitioner

Conclusion

Evidence shows that care-seeking for fever in children may be increasing, but barriers to timely care-seeking should be investigated and addressed in Burkina Faso to prevent severe disease and death.

Key Question 2

What is known about the major barriers and facilitators to care-seeking?

Supporting Data

Figure A24. Major Barriers and Facilitators to Care-Seeking in Burkina Faso

Facilitator	Type of Factor	Data Source	Evidence
Free care for pregnant women and children under five years of age	Environmental	HMIS data	When this policy was implemented in 2016, there was a significant increase in malaria cases in this group, implying that care seeking could be influenced by this policy.
Barrier	**Type of Factor**	**Data Source**	**Evidence**
Further distance to care	Environmental	Sarrassat, S., Meda, N., Badolo, H., Ouedraogo, M., Somé, H., & Cousens, S. (2019). Distance to care, care seeking and child mortality in rural Burkina Faso: findings from a population-based cross-sectional survey. Tropical medicine & international health, 24(1), 31-42.	Results from a survey showed that a larger distance to the closest health facility associated with (marginally) higher neonatal mortality

Conclusion

Data are lacking on key barriers and facilitators to care-seeking. However, evidence suggests that behavior varies by region ranging from 52 percent to 87 percent care seeking for children under five[2], indicating that predictors of behavior and therefore the strategies needed to address behavior is likely to also vary. More information is needed to address care seeking in Burkina Faso.

Key Question 3

How have malaria testing and treatment practices evolved over time?

[2] Burkina Faso MIS https://dhsprogram.com/pubs/pdf/MIS32/MIS32.pdf

Supporting Data

Figure A25. Malaria Cases Confirmed by a Diagnostic Test and Treated with an ACT, 2012 - 2018

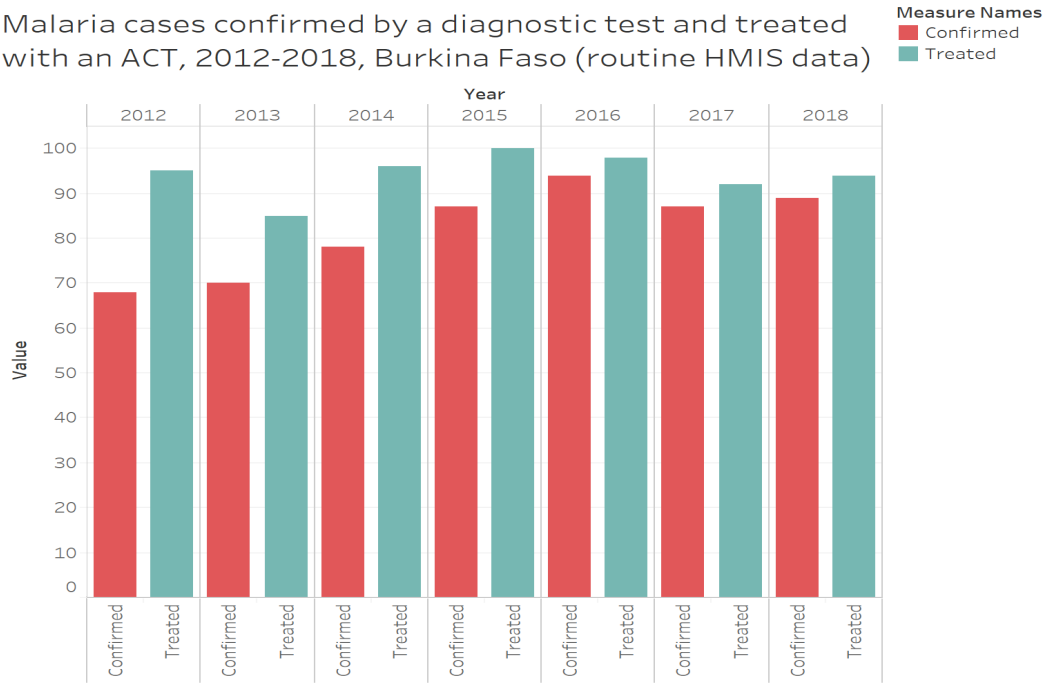
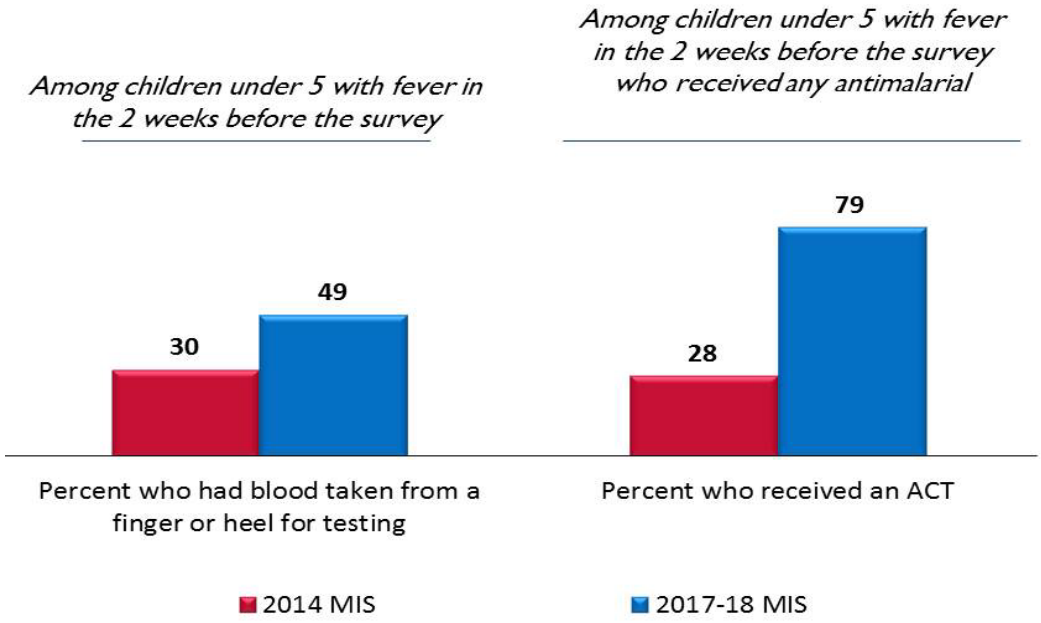


Figure A26. Trends in Diagnosis and Treatment of Children with Fever



Conclusion

Evidence from routine health system data shows that the percentage of cases confirmed using a parasitological test and treated with an ACT increased between 2012 and 2015, though there is

still room for improvement. While routine data show generally high rates of treatment in the public sector, there is a need for further supervision, training, and investigation to barriers to achieving the NMCP goal of 100 percent diagnosis of suspected cases and 100 percent correct treatment of confirmed cases.

Key Question 4

What is known about provider behavior in relation to testing and treatment practices?

Supporting Data

Figure A27. Key Barriers and Facilitators to Appropriate Testing and Treatment Practices

Facilitator	Type of Factor	Data Source	Evidence
General knowledge of malaria	Internal	*Evaluation de la qualité de la prise en charge du paludisme dans les formations sanitaires publiques du Burkina Faso*, 2017	The majority of health workers (69%) interviewed had a good understanding of malaria in general
Availability of RDTs	External	2018 SARA (preliminary report)	The 2018 report found that RDTs were available in almost all facilities. In rural areas, availability was 100%, in urban availability was 93%.
Barrier	**Type of Factor**	**Data Source**	**Evidence**
Knowledge of specific domains of malaria case management	Internal	*Evaluation de la qualité de la prise en charge du paludisme dans les formations sanitaires publiques du Burkina Faso*, 2017 2018 Service Availability and Readiness Assessment (SARA) (Preliminary report)	While overall knowledge was high, there were gaps in knowledge on treatment for severe malaria and IPTp among providers interviewed
Stockouts of commodities	External		Stockouts of RDTs and ACTs at the health facility level are negatively associated with CM according to established guidelines. While RDTs were found to be available at most facilities visit, 20% of facilities did not have ACTs available.
Training of staff	External	2018 SARA (preliminary report)	Only 70% of staff interviewed were trained in the diagnosis and treatment of malaria.

Conclusion

There is evidence that adherence to the national malaria case management guidelines varies throughout the country at the health center and hospital levels. A PMI-supported 2017 study found that one third of uncomplicated malaria cases among children and one half of pregnant women were not treated in line with national directives at health centers. Data are not available about how the children and pregnant women and children not treated according to the guidelines were treated. Furthermore, two-thirds of severe malaria cases among children under five and pregnant women were not treated according to the guidelines[3]. While stockouts were found to be frequent at the health center level, more investigation is needed to understand the predictors of adherence or non-adherence to the guidelines.

Furthermore, the little evidence that exists on healthcare provider behavior is from the public sector, and there is little insight into the practices and availability of services in the private sector. The 2018 SARA found a disparity in operational readiness (training, availability of guidelines and commodities) for the treatment and diagnosis of malaria between the public and private sector, with public facilities scoring an average of 84 percent for operational readiness, and the private sector 46 percent.

Key Question 5

What is the current and planned support for case management at health facilities and in the communities by CHWs?

Supporting Data

Figure A28. Donor Support by Intervention Areas for Community-Level Support

Intervention Area	GoBF	WHO	UNICEF	Global Fund	World Bank	PMI
Diagnosis	X	X	X	X	X	X
Treatment	X		X	X	X	X
CHW incentives	X			X		
CHW program	X		X	X	X	X
SBC	X	X	X	X	X	X

Conclusion

For case management, there is no geographic delineation of partners in Burkina Faso. Partners supporting intervention areas generally provide nationwide support, unless it is for a location-specific intervention, such as the pilot of pre-referral treatment. Any gaps in coverage will be by intervention, not by geography.

[3] *Evaluation de la qualité de la prise en charge du paludisme dans les formations sanitaires publiques du Burkina Faso,* 2017

Key Question 6

What was the estimated need for RDTs during calendar year 2019? What are the estimated RDT needs over calendar years 2020 and 2021?

Supporting Data

Figure A29. Gap Analysis of RDT Needs

Calendar Year	2019	2020	2021
RDT Needs			
Total country population	20,870,060	21,478,529	22,144,363
Population at risk for malaria [1]	20,870,060	21,478,529	22,144,363
PMI-targeted at-risk population	20,870,060	21,478,529	22,144,363
Total number of projected fever cases [2]	17,796,511	18,761,082	19,590,322
Percent of fever cases tested with an RDT [3]	100%	100%	100%
Total RDT Needs [4] (including 6 months buffer stock)	**17,796,511**	**28,141,623**	**29,385,483**
Partner Contributions (to PMI target population if not entire area at risk)*			
RDTs carried over from previous year	*8,025,614*	*5,862,900*	*0*
RDTs from Government			
RDTs from Global Fund	7,060,797	5,469,987	
RDTs from other donors			
RDTs planned with PMI funding	8,573,000	7,750,000	7,000,000
Total RDTs Available	**23,659,411**	**19,082,887**	**7,000,000**
Total RDT Surplus (Gap)	**5,862,900**	**-9,058,737**	**-22,385,483**

Footnotes:

1. Total country population and population at risk of malaria: Demographic Projections -INSD (*Institut National de la Statistique et de la Démographie*) 2011-2020; and 2021 with population growth rate of 3.1%.
2. Total number of projected fever cases: The forecast is based on number of fevers reported through HMIS data base. The average increase between 2017-2018 and 2018-19 is 5.42%, and it is maintained for 2020 (quantification committee). Taking into consideration the impact of planned interventions (2019 LLIN mass campaign, Implementation of IRS in three districts , SMC Scaling to all the districts, High Burden High Impact activities implementation, Malaria Elimination Initiative in the Sahel), and based on improved compliance with treatment guidelines, the quantification committee has decided to adjust the projected increase rate at 4.42% from 2020 to 2021.
3. Percentage of fever cases tested with an RDT: 100% of fever cases expected at the health facilities and at the community level will be tested with an RDT.
4. Total RDT Needs: 6 months buffer stock is considered in 2020 and 2021 total needs .

Conclusion

PMI plans to procure seven million single species (*Pf)* RDTs for Burkina Faso in CY 2021 and procured 7.75 million RDTs for 2020. Support from the Global Fund, the other procurer or RDTs in Burkina Faso is not known at the time of writing this MOP and PMI's support will only fill about 25 percent of the total need in 2021. There will likely be a significant gap in RDTs for calendar year 2021.

Key Question 7

What was the estimated need for ACTs during calendar year 2019? What is the estimated need for ACTs over calendar years 2020 and 2021?

Supporting Data

Figure A30. Gap Analysis of ACT Needs

Calendar Year	2019	2020	2021
ACT Needs			
Total country population	20,870,060	21,478,529	22,144,363
Population at risk for malaria	20,870,060	21,478,529	22,144,363
PMI-targeted at-risk population [1]	20,870,060	21,478,529	22,144,363
Total projected number of malaria cases [2]	12,457,883	12,633,539	12,570,371
Total ACT Needs [3] (including 6 months buffer stock)	**12,457,883**	**18,950,309**	**18,855,557**
Partner Contributions (to PMI target population if not entire area at risk)[1]			
ACTs carried over from previous year	9,297,499	6,112,145	0
ACTs from Government			0
ACTs from Global Fund	2,822,529	0	
ACTs from other donors	0	0	0
ACTs planned with PMI funding	6,450,000	6,000,000	6,000,000
Total ACTs Available	**18,570,028**	**12,112,145**	**6,000,000**
Total ACT Surplus (Gap)	**6,112,145**	**-6,838,164**	**-12,855,557**

Footnotes:

1. Total country population and population at risk of malaria: Demographic Projections -INSD (*Institut National de la Statistique et de la Démographie*) 2011-2020; and 2021 with population growth rate of 3.1%.
2. Total projected number of malaria cases: The forecast of number of malaria cases for 2020 is based on the average increase between 2017-2018 and 2018-19 (1.41%). With the various preventive interventions and improved compliance with the treatment guidelines, the quantification committee has decided to consider a reduction of 0.50% for 2021.
3. Total ACT Needs: Annual needs plus 6 month buffer stock for 2020 and 2021

Conclusion

PMI plans to procure six million ACTs for Burkina Faso in calendar year 2021 and procured six million ACTs for 2020. In 2020, there was a gap of six million ACTs that the Global Fund plans to address with emergency funds. Support from the Global Fund for 2021 for Burkina Faso is not known at the time of writing this MOP and PMI's support will only fill about one third of the total need in 2021.

Additionally, considering the results of the most recent therapeutic efficacy study, the NMCP will likely update its case management policy and PMI anticipates procuring either artesunate-pyronaridine or DP, the cost estimates of which are not stable due to the time the artesunate-pyronaridine has been on the market and the limited demand of DP. Irrespective of the cost of artesunate-pyronaridine or DP , there is likely to be another ACT gap in Burkina Faso in 2021.

Key Question 8

What was the estimated need for severe malaria treatment and any other treatments as applicable during calendar year 2019?What is the estimated need for calendar years 2020 and 2021?

Supporting Data

Figure A31. Gap Analysis of Injectable Artesunate Needs

Calendar Year	2019	2020	2021
Injectable Artesunate Needs			
Projected Number of Severe Cases[1]	**561,507**	**559,291**	**557,269**
Projected # of severe cases among children	283,627	286,577	289,557
Projected # of severe cases Pregnant Women	32,278	30,280	28,405
Projected # of severe cases among adults (excluding pregnant women)	245,603	242,434	239,307
Artesunate injectable Needs including buffer stock [2]			
Children under five years of age (4 ampoules per case)	1,134,508	1,146,307	1,158,229
Pregnant women (12 ampoules per case)	387,332	363,356	340,864
Population over 5 years of age excluding Pregnant women (8 ampoules per case)	1,964,820	1,939,474	1,914,455
Total Injectable Artesunate vials Needs [2]	**3,486,660**	**3,449,137**	**3,413,548**
Total Artesunate injectable Needs [3] (including 6 months buffer stock)	**3,486,660**	**5,173,706**	**5,120,322**
Partner Contributions			
Injectable artesunate vials carried over from previous year	1,979,899	459,450	0
Injectable artesunate vials from Government	0	0	0
Injectable artesunate vials from Global Fund	376,211	0	
Injectable artesunate vials from other donors	0	0	0
Injectable artesunate vials planned with PMI funding	1,590,000	1,000,000	1,000,000
Total Injectable Artesunate vials Available	**3,946,110**	**1,459,450**	**1,000,000**
Total Injectable Artesunate vials Surplus (Gap)	**459,450**	**-3,714,256**	**-4,120,322**

Footnotes:

1. **Projected Number of Severe Cases**: Sum of the projected # of severe cases among children, Pregnant Women, and adults (excluding pregnant women):
   Projected # of severe cases among children are based on the percentage increase of 1.04% observed between 2017-2018.
   Projected # of severe cases among pregnant women are based on the average percentage decrease observed between 2017 -2018 and 2018-2019 for severe malaria cases of severe malaria cases among pregnant women (6.19%) .
   Projected # of severe cases among adults (excluding pregnant women) are based on the average percentage decrease of severe malaria in adults cases between 2017 and 2018 and 2018-2019 (1.29%)

2. Number of ampoules for severe malaria treatment: The number of samples for each group are based on National Treatment Guidelines

3. Total Artesunate injectable Needs: Annual needs plus 6 months buffer stock for 2020 and 2021

Conclusion

PMI plans to procure one million vials of injectable artesunate for 2020 and 2021. Support for the procurement of injectable artesunate by the Global Fund for 2021 is not yet known, so it is unclear if and how large the gap will be.

PMI plans to support the purchase of rectal artesunate suppositories to cover pre-referral treatment in two regions to be chosen in consultation with the NMCP and based on the burden of severe disease and death among children under five years of age in addition to considering areas where access to health care is limited due to security.

Key Question 9

Are the first-line ACTs effective and monitored regularly?

Supporting Data

Figure A32. Recently Completed and Ongoing Antimalarial Therapeutic Efficacy Studies

Year	Sites	Treatment arms	PCR-corrected ACPR>90%?	Where molecular resistance work was completed or the plan, if any, for molecular resistance work
2017-2018	Gourcy, Nanoro, Niangoloko	AL, DP	AL 28-day efficacy <80% in 2 sites (75.1 in Nanoro, 75.6 in Gourcy) DP 42-day efficacy <90% in 2 sites (89.8 in Nanoro, 84.6 in Gourcy)	*Institut Pasteur*, Paris
2020	Gourcy, Nanoro, Niangoloko, others TBD	AL, DP, As-Pyr	N/A	CDC Laboratory Unit through the PMI-supported Antimalarial Resistance Monitoring Network (PARMA)

Footnotes - ACPR: adequate clinical and parasitological response; AL: artemether-lumefantrine; DP: Dihydroartemisinin-piperaquine; As-Pyr: Artesunate-pyronaridine PARMA: PMI-supported Antimalarial Resistance Monitoring in Africa

Conclusion

Past and recent evidence suggests that AL is not effective in at least two sites in Burkina Faso according to the WHO-recommended cutoff of 90 percent efficacy. The country is working to do a more in-depth analysis of the most recent TES results, on a transition plan to procure alternatives to AL, as well as a three-arm (AL, DP, As-Pyr) TES to take place in 2020.

Key Question 10

Are there other key items, such as lab strengthening, private sector support, etc. that should be considered?

Supporting Data

The current security situation in Burkina Faso will require a change of strategy to ensure that healthcare workers are being trained, have access to commodities, and data are tracked.

Conclusion

PMI will support the NMCP strategy to address malaria given the security situation by investing in mobile training activities and service delivery and data collection by CHWs, ensuring flexibility to change the geographic scope of activities as the situation evolves.

Key Question 11

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

N/A

Conclusion

N/A

2.B. DRUG-BASED PREVENTION

NMCP objective
SMC ● At least 95 percent of all children 3-59 months old in SMC target zones have been covered with four rounds of SMC with SP/AQ in the high transmission season. **MIP** ● At least 80 percent of pregnant women receive at least three doses of IPTp during prenatal care visits of their most recent pregnancy
NMCP approach
SMC ● The NMCP's approach is to provide SMC for children 3-59 months of age nationwide. **MIP** ● The NMCP's approach is to ensure SP is available at all health facilities nationwide and to require health workers to administer (and directly observe) SP to all pregnant women attending ANC at health facilities nationwide beginning at 13 weeks of pregnancy.
PMI objective, in support of NMCP
SMC ● Burkina Faso's SMC strategy aligns with the WHO recommendations for SMC eligibility. Therefore, PMI supports this strategy in Burkina Faso. Donor support for SMC is divided by district. **MIP** ● Improve national uptake of IPTp through inclusion in refresher trainings for health service providers ● Contribute to evidence-building on the effectiveness of community IPTp (cIPTp)through improving overall IPTp uptake through support of a cIPTp pilot in three districts

PMI-supported recent progress (past ~12-18 months)
SMC ● PMI supported SMC implementation of 12 districts in 2019, covering approximately 500,000 children 3-59 months old. **MIP** ● Training of 569 ANC providers on IPTp following the adoption of the 2016 WHO recommendations ● Roll out of a pilot for community IPTp delivery in three districts by training 108 CHWs and improving ANC-4 attendance from 61 percent to 77 percent while also improving IPTp-3 coverage from 50 percent to 61 percent and IPTp-4 coverage from 21 percent to 47 percent.
PMI-supported planned activities (next ~12-18 months, supported by currently available funds)
● PMI will support SMC in 12 districts, covering approximately 521,000 children in 2021. ● Training of 1,133 community health workers in the delivery of IPTp in three health districts

2.B.i SEASONAL MALARIA CHEMOPREVENTION (SMC)

PMI Goal
Support the national strategy for SMC addressing relevant geographic areas and age groups, which includes 4 rounds, 3-59 months old, in accordance with WHO recommendations

Do you propose expanding, contracting, or changing any SMC activities? If so, why, and what data did you use to arrive at that conclusion?
In previous years, PMI covered 14 districts, but two of them were in a region supported mostly by Global Fund, so for logistical simplicity, Global Fund will support two more districts. Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Key Question 1

What was the estimated need for SMC commodities during calendar year? What is the estimated need for SMC commodities over calendar years 2020 and 2021?

Supporting Data

Figure A33. Gap Analysis of SP+AQ Needs

Calendar Year	2019	2020	2021
SMC drug (SP+AQ) Needs			
Population targeted for SMC (3-59 months)	3,433,125	3,640,611	3,753,470
PMI-targeted population for SMC [1]	3,433,125	3,640,611	3,753,470
Population targeted for SMC (3-11 months)	573,927	590,660	608,970
Population targeted for SMC (12-59 months)	2,859,198	3,049,951	3,144,500
Total SP+AQ Needs for SMC (3-11 months) including 15% buffer stock [2]	**2,761,259**	**2,841,764**	**2,929,859**
Total SP+AQ Needs for SMC (12-59 months) including 15% buffer stock [3]	**14,172,027**	**15,117,521**	**15,586,164**
Total SP+AQ Needs (3-59 months) including 15% buffer stock	**16,933,286**	**17,959,285**	**18,516,023**
Partner Contributions (to PMI target population if not entire area at risk)			
SP+AQ carried over from previous year	*2,965,611*	*2,114,701*	
SP+AQ from Government			
SP+AQ from Global Fund*	2,682,919	2,757,306	2,700,000
SP+AQ from Malaria Consortium**	10,994,457	6,738,000	6,700,000
SP+AQ planned with PMI funding	2,405,000	2,460,000	2,000,000
Total SP+AQ Available	**19,047,987**	**14,070,007**	**11,400,000**
Total SP+AQ Surplus (Gap)	**2,114,701**	**-3,889,279**	**-7,116,023**

Footnotes:

1. Population targeted for SMC (3-59 months): Number of children 3-59 months living in the SMC-targeted districts (Demographic Projections - *Institut National de la Statistique et de la Démographie* 2011-2020); population growth rate is 3.1%. All the 70 districts are covered by SMC from 2019;

2. Total SP+AQ Needs for SMC (3-11 months) : Average target progressions between cycles 1-2, 2-3 and 3-4 is 3% which was used to project the number of SP + AQ treatments needed for the second, third and fourth cycles from 2020 assuming that this trend will continue in 2021; 15% of buffer stock was used to mitigate any losses.

3. Total SP+AQ Needs for SMC (12-59 months): For this target, the progression has been adjusted to 5% to take into account children who would have more than 59 months and who remain in the target (new entries at each round and no exit before the end of the campaign).
This adjusted average percentage was used to project the number of SP + AQ treatments needed for the second, third and fourth cycles from 2020 with the assumption that this trend will continue in 2021; 15% of buffer stock was used to compensate for losses. Once the 2021 -2023 Global Fund grant is developed, it will provide the Global Fund contribution for 2021 as well as the other donors' contributions.

* Global Fund support is still being negotiated in conjunction with the above allocation funding request. The plan is for GF to support 33 districts, taking on additional World Bank districts from 2019.

** Malaria Consortium support is also in discussion, but MC is hoping to cover ~23 districts (similar to their support in 2019).

Conclusion

PMI will support 12 districts for SMC, including commodity procurement and implementation, in FY 2020. Other donors have not yet specified their support for FY 2020, but expect to work together to fill the gap.

Key Question 2

What are the estimated non-commodity resource needs to properly deliver SMC over the next three years?

Supporting Data

The non-commodity cost refers to operational costs and includes a range of activities such as planning, training, implementation, supervision, monitoring, transportation, materials, equipment, and campaign evaluation.

Conclusion

The non-commodity costs for the PMI-supported districts are estimated to be $1.8 million.

Key Question 3

What does the data show about SMC refusal rates? How do refusal rates change from round to round? What barriers are contributing to SMC refusal rates?

Supporting Data

Data show that SMC refusal rates in Burkina Faso are low. In 2018, there was a nationwide 0.32 percent refusal rate overall. An independent monitoring study in 2019 shows that 100 percent of parents interviewed were satisfied with the SMC campaign, and 93.29 percent of children interviewed received the 2nd and 3rd dose at home. However, there are some districts that showed less than 80 percent coverage on the first pass. This is more likely due to logistical challenges of the campaign and not refusal.

Additionally, there are concerns in Burkina Faso that there is a "bounce back" in cases about two weeks after the SMC campaigns. This could be due to a lower-than-measured adherence to the 2nd and 3rd dose taken at home. Investigation into this issue and if directly observed therapy on all three days of the campaign would increase the effectiveness of SMC would provide data needed to ensure this nationwide investment is optimized.

Figure A34. Key Barriers and Facilitators to SMC Acceptance and Uptake

Facilitator	Type of Factor	Data Source	Evidence
Established CHW network	External	NA	An established network of CHWs from communities to oversee the SMC campaigns could impact adherence to SMC, but no concrete data exist to confirm this hypothesis.
Strong community engagement	Social	Campaign data	100% of parents interviewed reported that they were satisfied with the SMC campaign.

Barrier	Type of Factor	Data Source	Evidence
Adherence to the 2nd and 3rd dose	Internal	Routine data	There is some evidence that cases increase two weeks after the campaign, which could potentially be linked to non-adherence of the 2nd and 3rd dose, but there is no evidence to confirm this hypothesis.

Conclusion

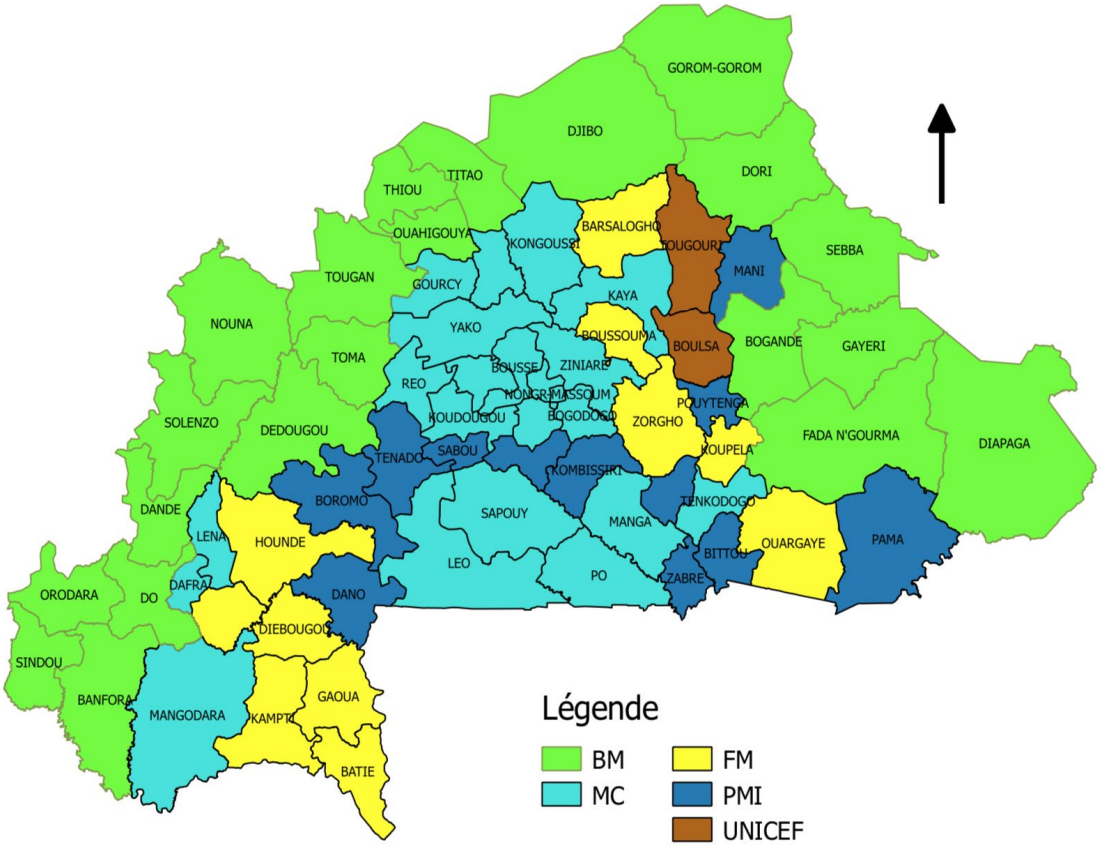
Overall, there is high acceptance of SMC in Burkina Faso, potentially due to strong community engagement and nationwide high epidemiologic burden. However, more evidence is needed regarding adherence to the 2nd and 3rd dose and about predictors of adherence to SMC in general.

Key Question 4

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

Figure A35. Partner-Supported SMC for CY 2019



Source: NMCP

BM: World Bank, MC: Malaria Consortium, FM: Global Fund

Conclusion

Figure A35 shows the CY 19 division of support by partner for SMC. To see PMI-supported districts in FY 2020, please see Figure 8 "Where we work" map or Table 2. The division of districts by non-PMI partners is not yet available at the time of MOP writing.

2.B.ii MALARIA PREVENTION IN PREGNANCY (MIP)

PMI Goal
Support the national strategy for MIP, which includes free provision of ITNs at first antenatal care (ANC) visit, intermittent preventive treatment for pregnant women (IPTp) to all pregnant women nationwide starting at 13 weeks gestational age, for a minimum of three doses, and effective case management of malaria, in accordance with WHO recommendations

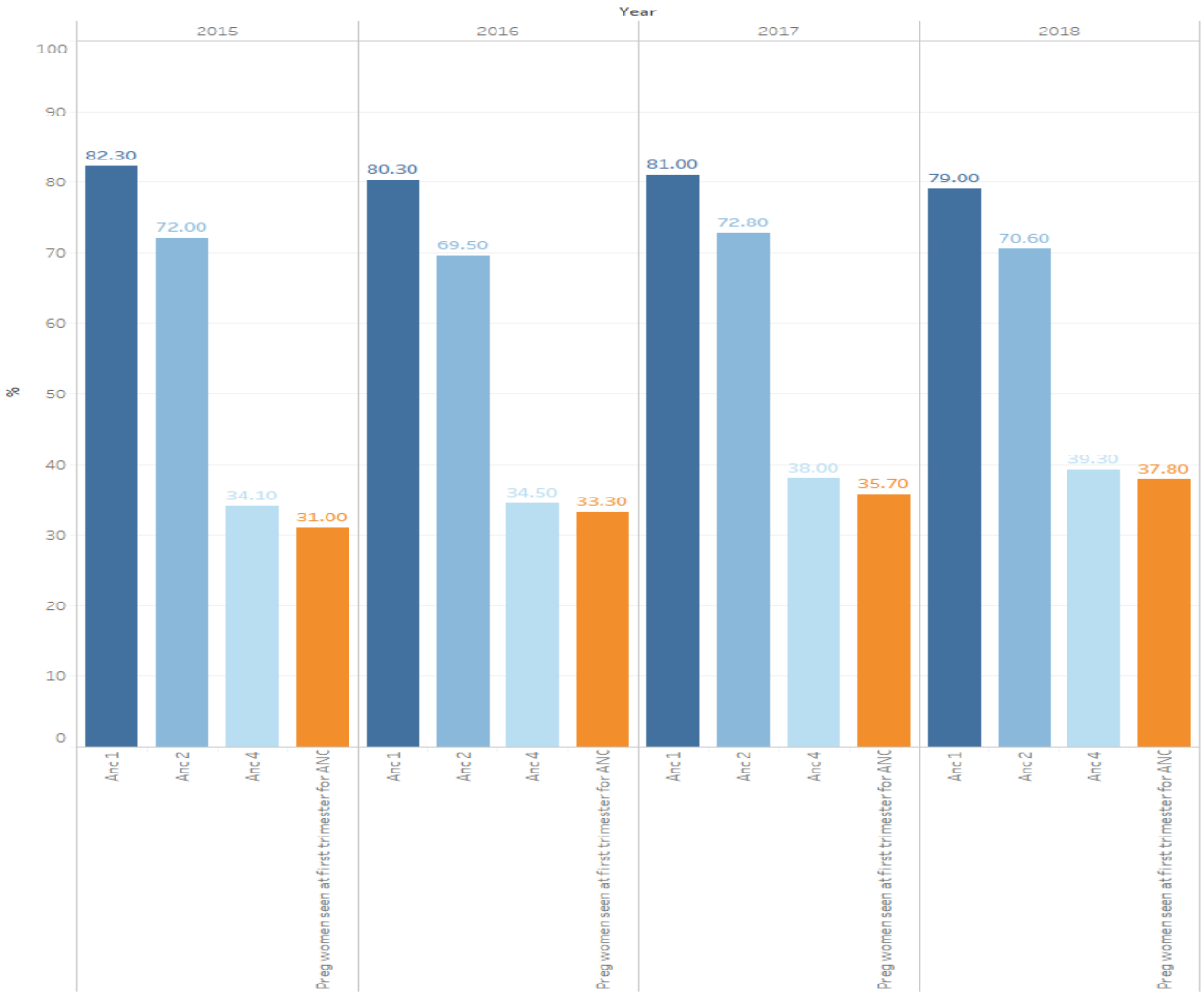
Do you propose expanding, contracting, or changing any MIP activities? If so, why, and what data did you use to arrive at that conclusion?
PMI-funded a pilot for community delivery of IPTp from 2018 - 2019 covering six CSPS and 108 CHWs within three districts (two per district). This pilot will be expanded to cover all 58 CSPS and 1133 CHWs within the pilot districts. Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Key Question 1

What proportion of pregnant women are receiving ANC early and frequently during their pregnancy?

Supporting Data

Figure A36. Percent of Pregnant Women in Burkina Faso Receiving ANC Visits 1-4 & Percent of Pregnant Women Seen at First Trimester for ANC, 2015-2018



Data source: DHS/MIS survey data

Figure A37. Key Barriers and Facilitators to ANC Attendance

Facilitator	Type of Factor	Data Source	Evidence
Proximity to health facility, ethnic origin, previous attendance of ANC	Environmental, Social	Determinants of utilization of maternal care services after the reduction of user fees: A case study from rural Burkina Faso[4]	Living within 5km of a health facility, previous attendance of ANC and certain ethnic groups (Mossi and Peuhl) are associated with increased ANC attendance

[4] De Allegri, M., Ridde, V., Louis, V. R., Sarker, M., Tiendrebéogo, J., Yé, M., ... & Jahn, A. (2011). Determinants of utilisation of maternal care services after the reduction of user fees: a case study from rural Burkina Faso. *Health policy*, *99*(3), 210-218.

Barrier	Type of Factor	Data Source	Evidence
Religious beliefs, increased household income and ethnic origin	Social	Determinants of utilization of maternal care services after the reduction of user fees: A case study from rural Burkina Faso[5]	Certain religious beliefs, higher household income and certain ethnic groups (Samo and Marka) are negatively associated with ANC attendance.

Conclusion

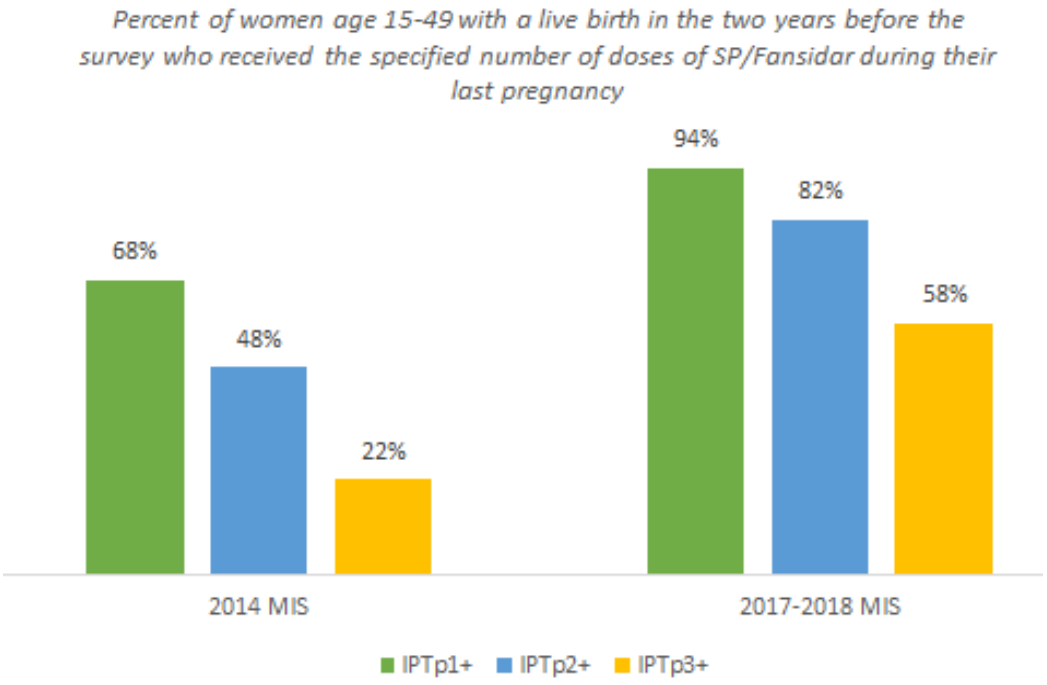
Burkina Faso has adopted the 2016 WHO ANC guidance and encourages early initiation of IPTp, beginning at 13 weeks. The primary challenges to implementation of the guidelines remain a relatively late start to ANC for the majority of pregnant women. Even though an increasing proportion of women are being seen during the first trimester of pregnancy since 2015, only a third of women are seen during this time, which reduces the potential number of contacts for future IPTp delivery over the course of the pregnancy.

Key Question 2

What proportion of pregnant women are receiving the recommended doses of IPTp?

Supporting Data

Figure A38. Trends in IPTp



Note that these indicators have been recalculated according to the newest definition, at least the specified number of doses of SP/Fansidar from any source

Conclusion

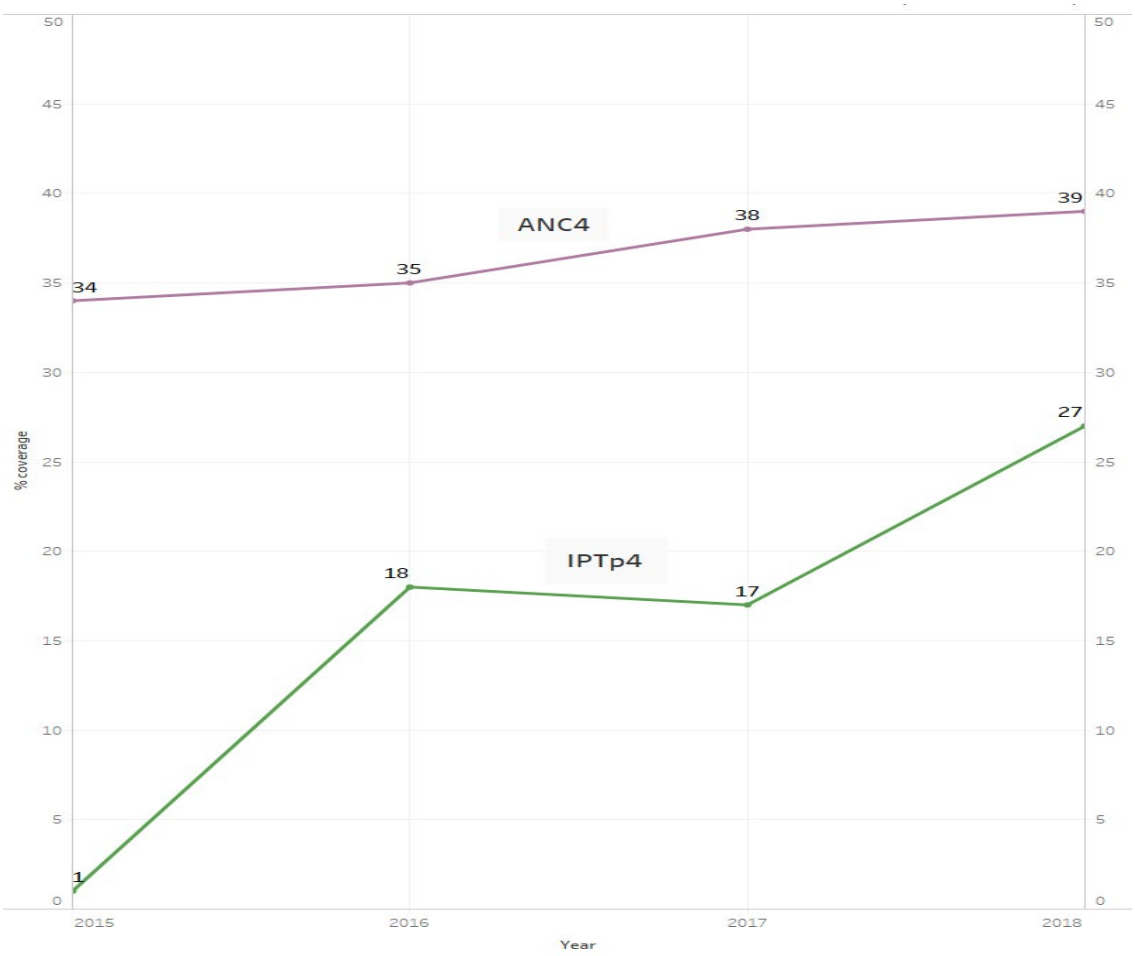
Trends in IPTp have shown dramatic improvement, with almost all women receiving at least one round of IPTp. Latest 2018 data show more than half of women receive at least three rounds of IPTp, more than double the rate in 2014.

Key Question 3

What is the gap between ANC attendance and IPTp uptake? What barriers and facilitators exist, especially among providers?

Supporting Data

Figure A39. ANC Visit 4 Attendance and IPTp Update, 2015 – 2018, Burkina Faso (Routine Data)



2018 (ANC-1, 2, 4): 79.0, 70.6, 39.3;
2017 (ANC-1, 2, 4): 81.0, 72.8, 38.0
2016 (ANC-1, 2, 4): 80.3, 69.5, 34.5
2015 (ANC-1, 2, 4): 82.3, 72.0, 34.1

Figure A40. Key Barriers and Facilitators to IPTp Administration at ANC Visits

Facilitator	Type of Factor	Data Source	Evidence
Availability of SP at the health facility level	Environmental	PMI-funded cIPTp pilot	Ensuring availability of SP at study sites for the entire duration of the study contributed to significant improvement in IPTp uptake in study sites compared to non-study sites.
Targeted SBCC	Social	PMI-funded cIPTp pilot	Reinforced SBCC using CHWs contributed towards improving IPTp uptake in study sites compared to non-study sites.
Barrier	**Type of Factor**	**Data Source**	**Evidence**
Insufficient training for health personnel	Environmental	PMI-funded cIPTp pilot	Health areas where staff did not receive training, re-training, and supportive supervision (non-study sites) had lower IPTp uptake compared to study sites.

Conclusion

ANC attendance rates continue to be notably higher than IPTp coverage at each visit. SBC approaches using CHWs could help reduce this gap as shown in the PMI-funded cIPTp pilot in three districts. In addition, supply chain strengthening efforts to ensure constant availability of SP at the health facility level as well as on-the-job training and supportive supervision of health care workers, all areas in which PMI is and will continue to be involved with funding are also likely to improve this indicator.

Key Question 4

What proportion of pregnant women with fever and malaria infection are getting diagnosed and treated?

Supporting Data

Not currently available in country

Conclusion

PMI plans to work with CHAI and NMCP during and after the planned evaluation of the malaria surveillance system and as part of the workstream A collaboration to ensure that this data is eventually captured in the routine HMIS.

Key Question 5

What was the estimated need for IPTp commodities during calendar year 2019? What is the estimated need for IPTp commodities over calendar years 2020 and 2021?

Supporting Data

Figure A41. Gap Analysis of SP Needs

Calendar Year	2019	2020	2021
Total Population at Risk [1]	20,870,060	21,478,529	22,144,363
SP Needs			
Total number of pregnant women [2]	929,785	930,436	931,087
Number of doses per pregnant woman [3]	4	4	4
Total SP Need (in treatments) (including 6 months buffer stock) [4]	**3,719,140**	**5,582,616**	**5,586,522**
Partner Contributions			
SP carried over from previous years	8,339,157	4,620,017	3,205,277
SP from Government		4,167,876	
SP from Global Fund			
SP from Other Donors			
SP planned with PMI funding			0
Total SP Available	**8,339,157**	**8,787,893**	**3,205,277**
Total SP Surplus (Gap)	**4,620,017**	**3,205,277**	**-2,381,245**

Footnotes:

[1.] Total Population at Risk: Demographic Projections -INSD *(Institut National de la Statistique et de la Démographie*) 2011-2020 and 2021 with Population Growth Rate of 3.1%;

[2.] Total number of pregnant women: The forecast is based on number of women received at the health facilities for ANC1 because number of pregnant women attending ANC2 to ANC4 are very low (HMIS reports). From 2017 to 2018 and from 2018 to 2019 (estimated), the percentage increase in number of women attended ANC1 are respectively 0.203% and 0.352%. For 2020 and 2021 the quantification committee members agreed to use the average increase between 2017 - 2018 and 2018 - 2019 (estimated) which is 0.07%.

[3.] Number of doses per pregnant woman: Each Pregnant women will receive 4 doses, according to the NMCP guidelines for malaria prevention and case management; For the forecast of SP doses, the quantification committee decided to consider all the women attending ANC1 eligible to receive 4 doses of SP during their pregnancy. However, the pregnant women will receive each SP doses in their first and subsequent ANC visits accordingly.

[4.] Total SP Need (in treatments) is annual estimated consumption plus 6 months buffer stock for 2020 and 2021.

Conclusion

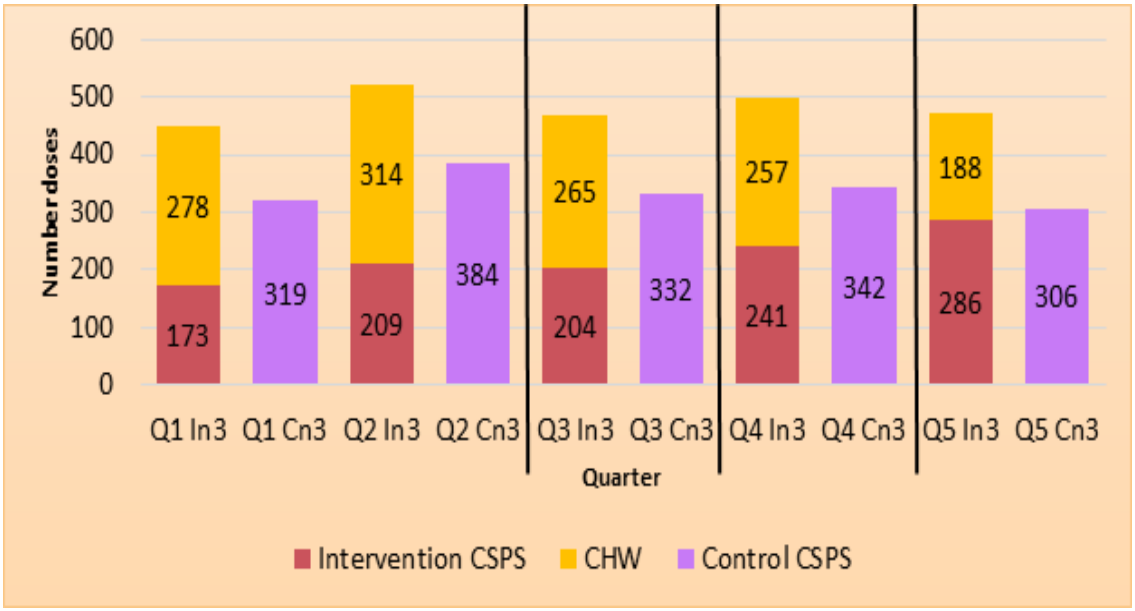
Historically, the GoBF has procured SP for IPTp. Therefore, PMI has not procured it and does not plan to for FY 2020.

Key Question 6

Are there any other considerations that impact your funding allocation in this category?

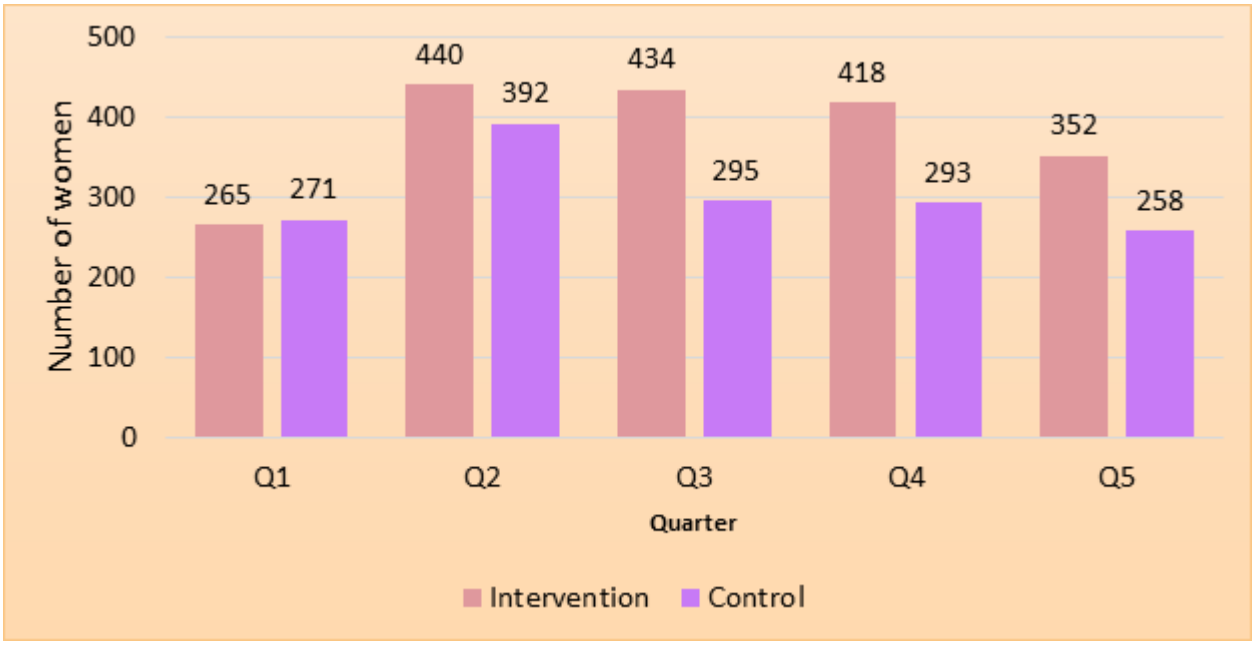
Supporting Data

Figure A42. Number of Third Doses of IPTp Administered According to Intervention Group and By Quarter, June 2017–August 2018



Source: Community IPTp Study[5]

Figure A43. Number of Women Who Completed Their Fourth Antenatal Care Contact According to Intervention Group and By Quarter, June 2017–August 2018



[5] Feasibility Study on Intermittent Preventive Treatment of Malaria in Pregnancy at the Community Level in Burkina Faso, September 2019.

Conclusion

The PMI-supported community IPTp OR study provided evidence that community-administered IPTp may increase the likelihood that pregnant women will receive the recommended doses of IPTp without having a negative effect on ANC attendance. PMI will continue to support this approach in the areas where the study took place.

3. CROSS-CUTTING AND OTHER HEALTH SYSTEMS

3.A. SUPPLY CHAIN

NMCP objective
The NMCP's objectives are to ensure an uninterrupted supply of malaria commodities and to strengthen the QA/QC of antimalarial medicines at all levels, in order to reduce the burden of malaria in Burkina Faso.
NMCP approach
Burkina Faso's supply chain strategy falls under Objective 3 of the NMCP's 2016-2020 strategic plan, which aims to strengthen the NMCP's managerial capacities. The NMCP recognizes that universal confirmation and treatment of malaria cases, scaling up prevention interventions through SMC for children 3-59 months, and IPTp can only be achieved in the context of a well-functioning pharmaceutical supply chain that minimizes the risk of stockouts and the use of counterfeit antimalarial drugs.
PMI objective, in support of NMCP
PMI fully acknowledges these aforementioned strategies and is committed to supporting the NMCP and CAMEG across all regions of Burkina Faso.
PMI-supported recent progress (past ~12-18 months)
PMI has supported various activities to strengthen the supply chain and supply chain management, including development of the 2019-2023 National Pharmaceutical Strategic Plan, annual commodities quantification exercises, optimization of the CAMEG and LMIS trainings for various cadres of the health system. Additionally, PMI has supported the integration of supply chain modules into pre-service training for incoming health workers, EUV exercises and the warehousing and distribution of malaria commodities across all regions in Burkina Faso.
PMI-supported planned activities (next ~12-18 months, supported by currently available funds)
PMI will continue to support annual commodities quantification exercises, rollout of LMIS trainings, pre-service training modules, EUV exercises, and the warehousing and distribution of malaria commodities.

PMI Goal

Ensure continual availability of quality products needed for malaria control and elimination (ACTs, RDTs, SP, Art. Inj., and ITNs) at health facilities and community level.

Do you propose expanding, contracting, or changing any supply chain activities? If so, why, and what data did you use to arrive at that conclusion?

PMI/Burkina Faso plans to maintain the support to strengthen supply chain systems in Burkina Faso. The FY2020 funding for supply chain will incrementally increase, due to the increased volume of commodities we are procuring with FY2020 funds. Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Key Question 1

Has the central level been stocked according to plan for ACTs, RDTs, SP and Art. Inj over the last year? If not stocked according to plan, have they been under, over or stocked out?

Supporting Data

Figure A44. Central Stock Level for ACTs

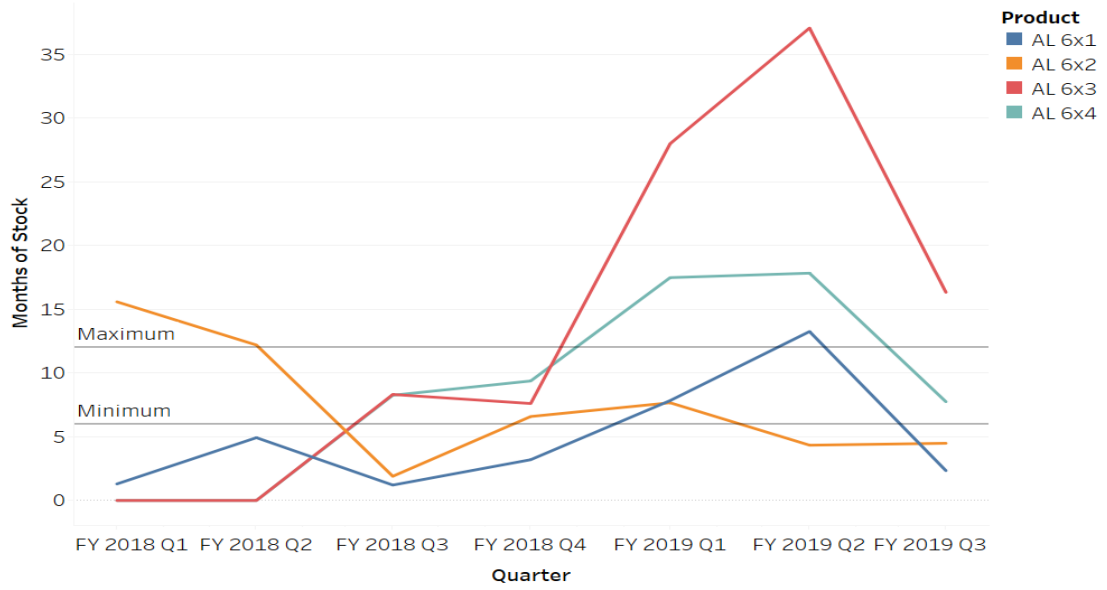


Figure A45. Central Stock Levels for SP and Injectable Artesunate, 60mg

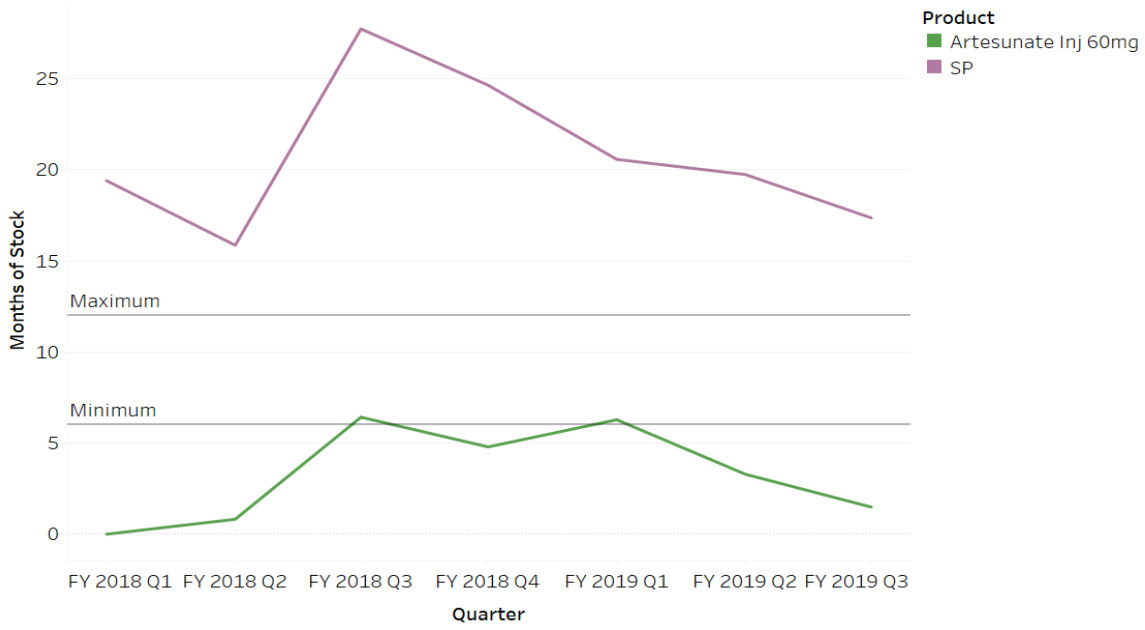
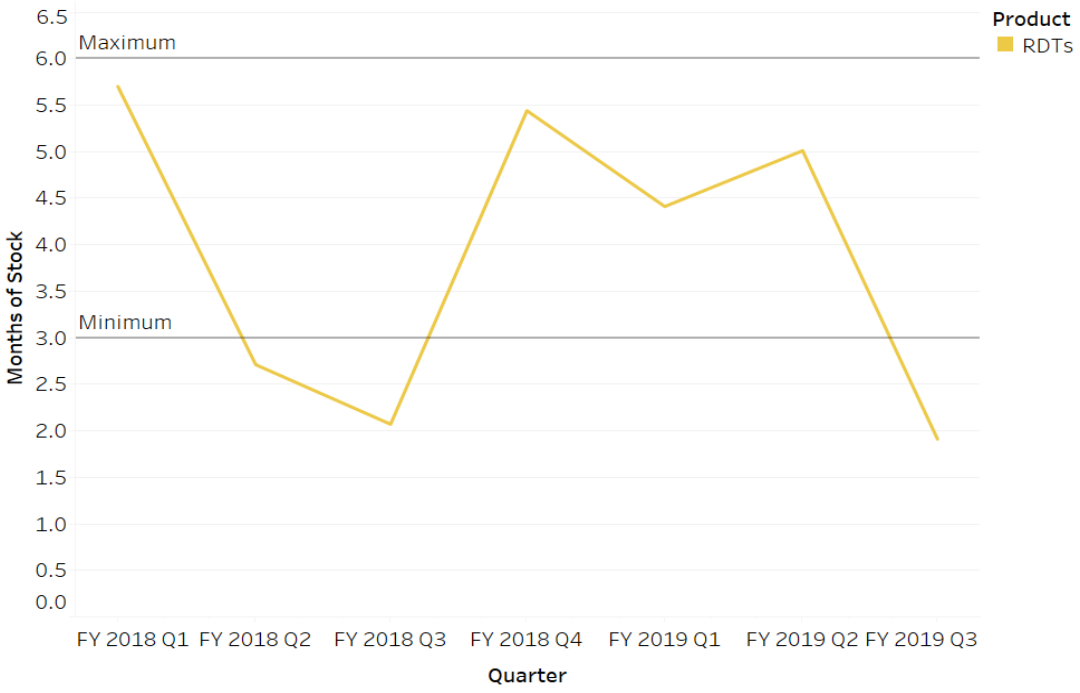


Figure A46. Central Stock Levels for RDTs



Conclusion

The stock levels of malaria commodities have generally been maintained within the max min levels, with some increases in stock availability prior to the higher transmission season.

Key Question 2

What are the trends in facility- and community health worker-level stock out rates for ACTs, RDTs, and SP over the last year (if tracked)? Is there a seasonal or geographic difference in stock out rates?

Supporting Data

Figure A47. AL Stockout Rates

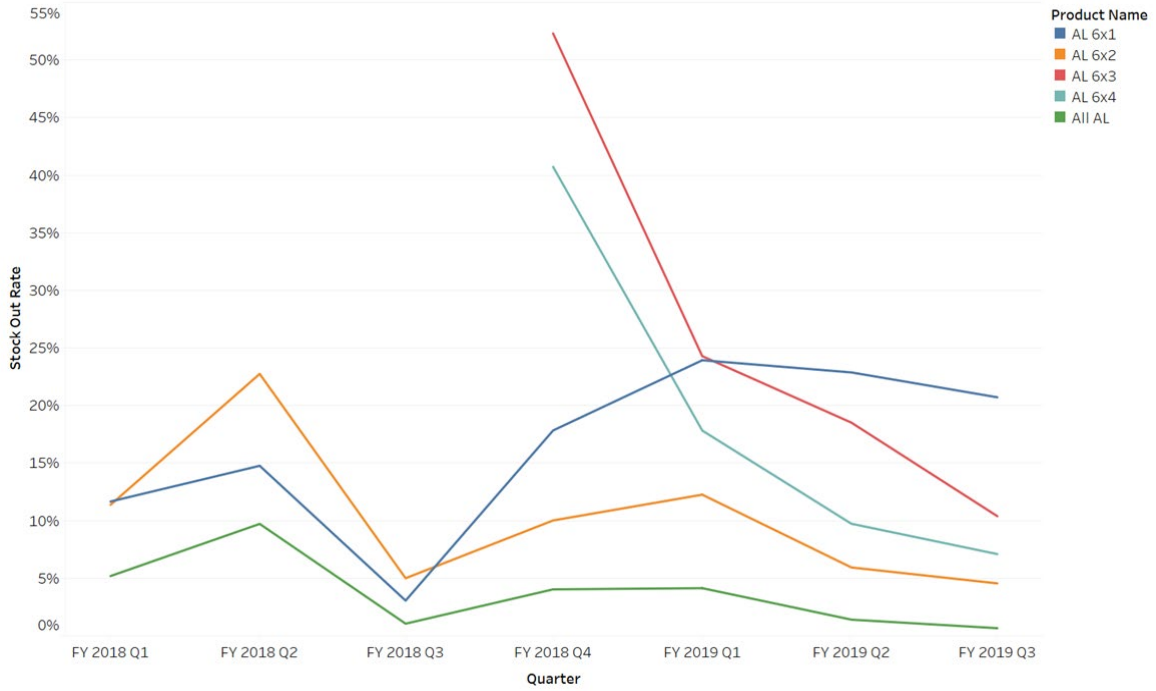


Figure A48. AS/AQ Stockout Rates

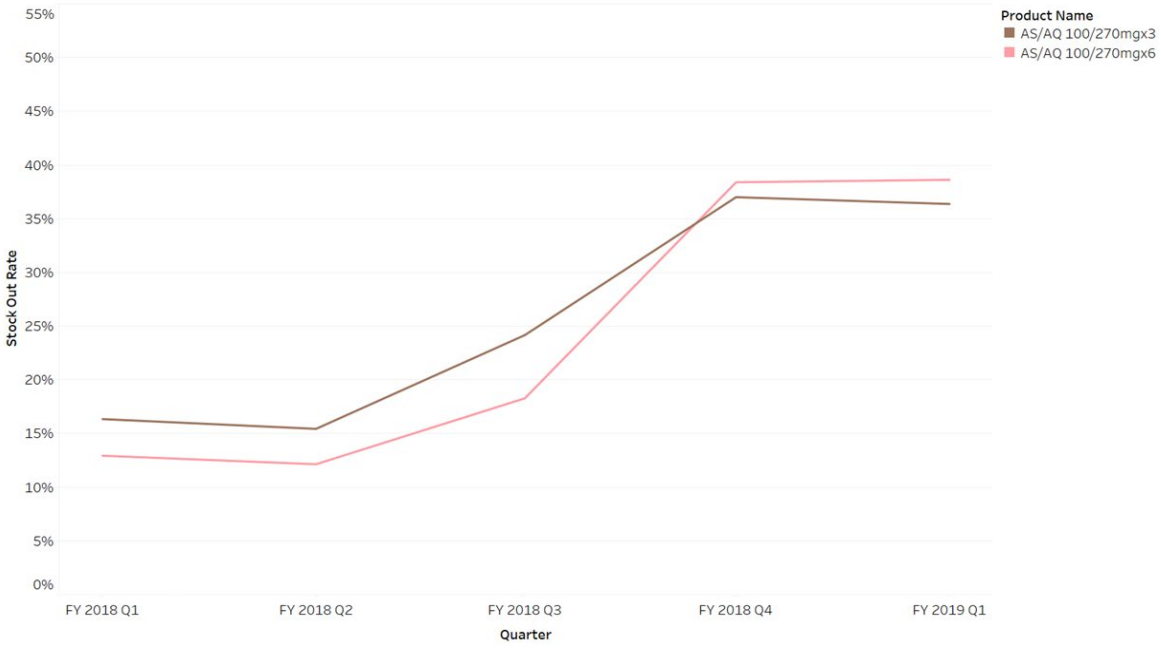
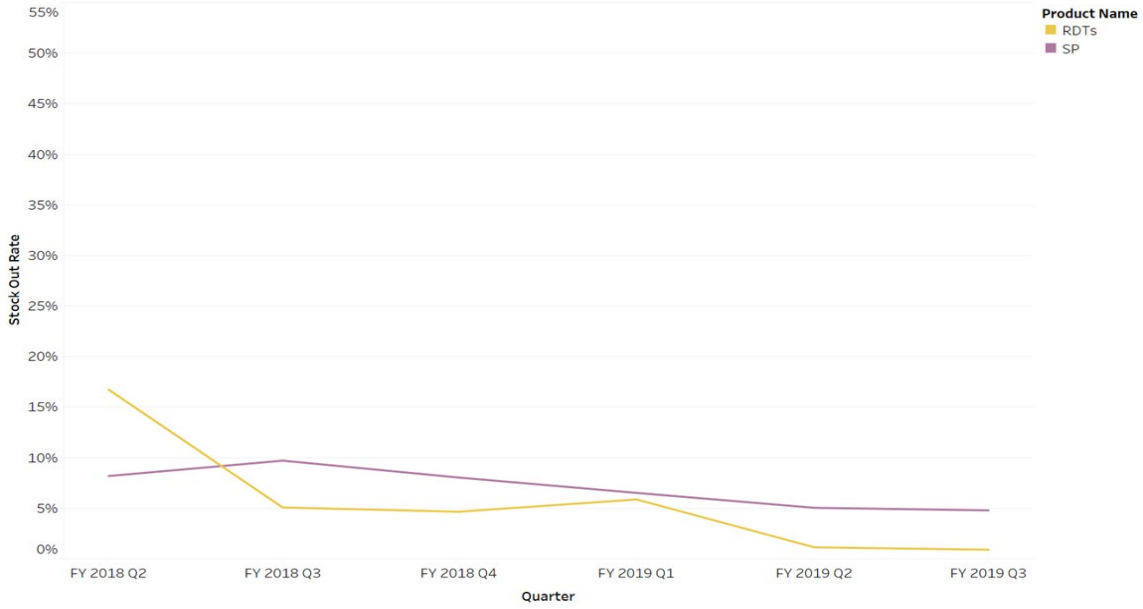


Figure A49. SP and RDT Stockout Rates



Conclusion

In general, stock out rates are pretty low for RDTs, SP, and most AL treatments. Even when there is a high stockout rate of certain AL presentations, stockouts of all ACTs consistently remain low (below 10 percent), indicating good availability to treat. The stock out rate for SP-AQ, which is used in our SMC campaigns, has an increased stock out rate after the fourth phase of the SMC campaign, which is not unusual.

Key Question 3

What is the difference between quantities for ACTs consumed and malaria cases, and RDTs consumed and numbers tested? What is driving any differences seen?

Supporting Data

No data available due to the 2019 health system strike.

Conclusion

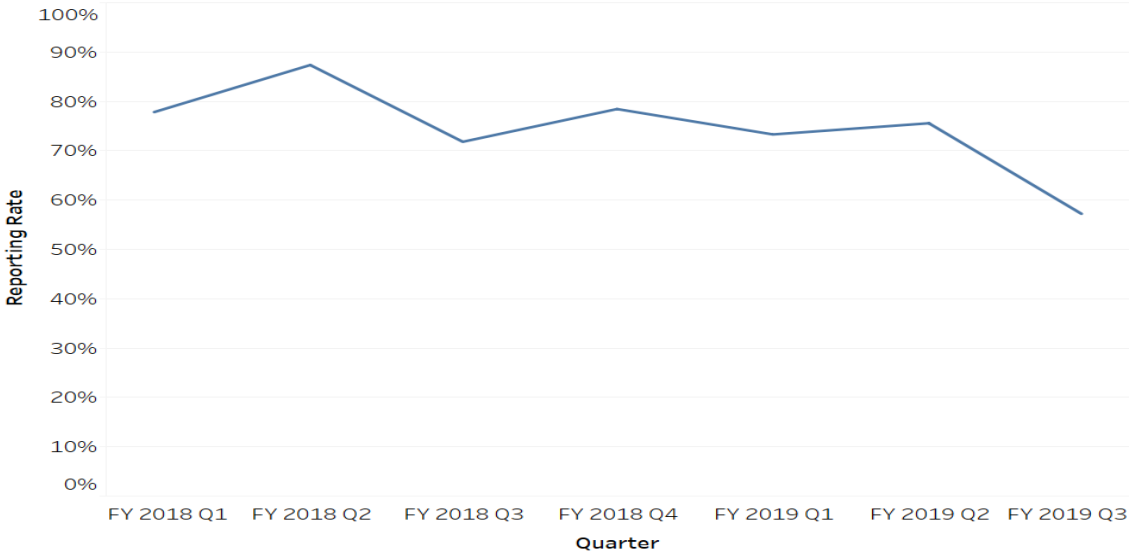
No data are available due to the 2019 data strike. However, PMI and partners continue to provide routine analysis and support to understand/rectify differences.

Key Question 4

What are the trends in LMIS reporting rates?

Supporting Data

Figure A50. LMIS Reporting Rate



Conclusion

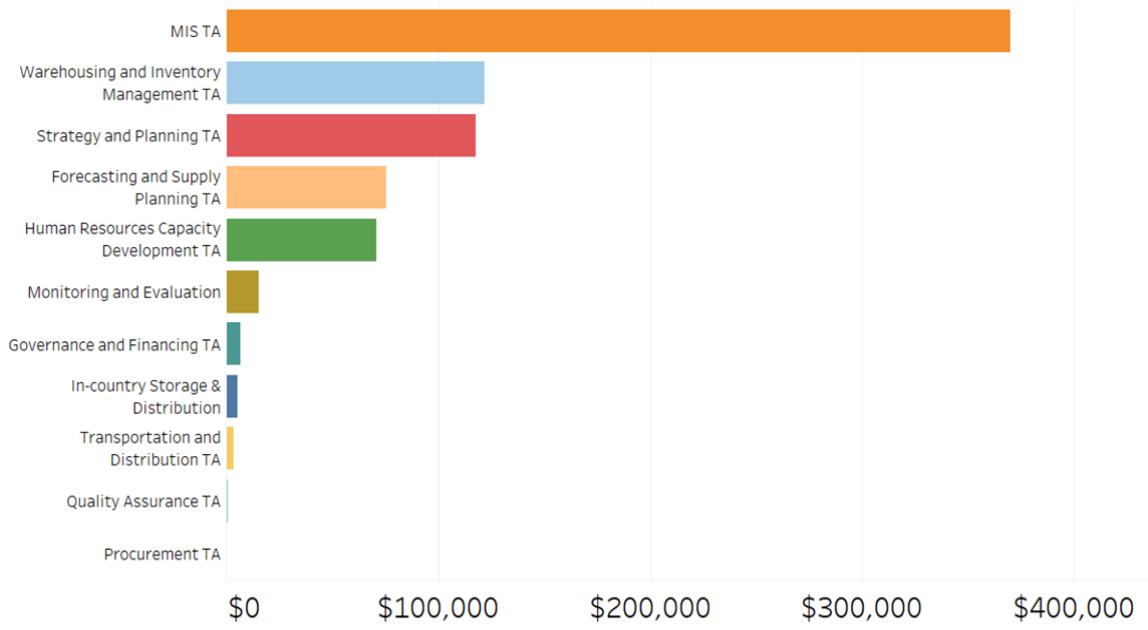
LMIS reporting rate has typically been above 70 percent. However, the downward trend in the graph above is attributed to the generalized health strike that began around May 2019.

Key Question 5

What are the main supply chain functions supported by PMI? For areas that are not as strong is there additional investment that PMI should make? In areas performing well, is it dependent on PMI/donor funding and so should be maintained?

Supporting Data

Figure A51. FY 18 Supply Chain Investments



Conclusion

CAMEG primarily depends on storage and distribution fees paid by PMI, Global Fund, UNICEF, World Bank and other donors and their performance is strongly tied to these fees which would continue to be supported by PMI funds. These fees were just starting to come through as expenditures in FY18 so they are underrepresented in the above graph but expect to be significantly higher in future years. Areas needing additional support accounted for in FY 20 include Quality Assurance TA with support for ISO certification which was specifically requested by CAMEG a priority area for support.

In addition, PMI plans to continue to focus on improving the LMIS and support capacity building for general supply chain management as much as possible. A large portion of the MOP budget is for the procurement of commodities, so ensuring a robust and secure supply chain is one of PMI's priorities.

Key Question 6

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

N/A

Conclusion

N/A

3.B. SURVEILLANCE, MONITORING & EVALUATION (SM&E)

NMCP objective

- To generate quality data on malaria in Burkina Faso
- To ensure the availability of data, including survey data, at opportune times

NMCP approach

Malaria SM&E activities are led by the M&E team at the NMCP, which oversees the data sources providing routine malaria data, as well as coordinating surveys and other studies aimed at monitoring NMCP interventions.

PMI objective, in support of NMCP

PMI is committed to supporting the NMCP in collecting high-quality, complete, and timely data on malaria morbidity, mortality, and commodity stocks from health facilities and CHWs. In addition, PMI works with the NMCP to support household surveys, health facility surveys, and efficacy studies to complement routine surveillance data.

PMI-supported recent progress (past ~12-18 months)

- Support for 20 participants in a malaria surveillance, monitoring and evaluation course
- Evaluation of quality of malaria case management
- Publication of a weekly malaria surveillance bulletin

PMI-supported planned activities (next ~12-18 months, supported by currently available funds)

- Support for data quality assurance missions at all levels of the health system to contribute to the feedback loop of improving data quality at the operational level
- Support for integration of data on commodities with epidemiologic data
- The implementation of a malaria-specific intermediate Field Epidemiology Training Program (FETP) cohort (15 participants) from the regional and central level to improve data collection, analysis, visualization, and interpretation at all levels of the health system (FY 2018 MOP funds)
- Support for one person from the NMCP to participate in the two-year advanced cohort of FETP (FY 2019 MOP funds)

PMI Goal

To support the NMCP to build their capacity to conduct surveillance as a core malaria intervention using high quality data from both surveys and routine health information systems.

Do you propose expanding, contracting, or changing any SM&E activities? If so, why, and what data did you use to arrive at that conclusion?

There is currently a comprehensive malaria surveillance system evaluation underway by CHAI supported by BMGF. PMI plans to support the implementation of the recommendations from this evaluation with FY 2020 funds.

Support for the malaria-focused FETP intermediate program will continue from FY 2018 by continuing the training of regional-level staff with the ultimate goal of training at least three MOH staff directly involved in malaria surveillance, monitoring and evaluation activities in each of the 13 health regions as well as at least six staff at the central level. Full coverage of the country would take three years. PMI plans to support an additional cohort of 15 malaria-focused participants in intermediate FETP with FY 2020 funds.

Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Key Question 1

Which sources of data are available to inform estimates of intervention coverage, service availability and readiness, and morbidity and mortality?

Supporting Data

Figure A52. Data Sources and Collection Activities, 2015 - 2023

Data Source	Data Collection Activities	Year								
		2015	2016	2017	2018	2019	2020	2021	2022	2023
Household Surveys	Demographic Health Survey (DHS)						(X)			
	Malaria Indicator Survey (MIS)			X^	X^				(X)	
	Multiple Indicator Cluster Survey (MICS)									
	EPI survey									
Health Facility Surveys	Service Provision Assessment (SPA)									
	Service Availability Readiness Assessment (SARA) survey				X					
	Other Health Facility Survey									
Other Surveys	EUV				X	X	(X)	(X)		

Data Source	Data Collection Activities	Year								
		2015	2016	2017	2018	2019	2020	2021	2022	2023
	School-based Malaria Survey									
	Other (Knowledge, Attitudes and Practices Survey, Malaria Behavior Survey)									
	Other (Malaria Impact Evaluation)									
Malaria Surveillance and Routine System Support	Support to Parallel Malaria Surveillance System#				X	X	(X)	(X)		
	Support to HMIS			X	X	X	(X)	(X)	(X)	(X)
	Support to Integrated Disease Surveillance and Response (IDSR)		X*	X*	X*	X*	(X*)			
	Other (Electronic Logistics Management Information System (eLMIS)						(X)	(X)		
	Other (Malaria Rapid Reporting System)									

*Asterisk denotes non-PMI-funded activities, x denotes completed activities and (x) denotes planned activities.

^The MIS in 2017 was implemented in the dry season, limiting comparability to previous MIS and ability to understand behavior during the high-transmission season.

#PMI supports entomologic, net durability and IRS data collections that are not yet fully integrated within the national HMIS.

Conclusion

PMI's primary support for malaria data sources continues to be focused on the national HMIS to ensure that it can provide timely and reliable malaria data and eventually minimize the need for expensive household surveys. In partnership with BMGF, efforts are underway to ensure that entomology data collection is strengthened and eventually integrated into the national HMIS. Support for supply chain information systems will be reinforced with continued support for EUVs and the introduction of eLMIS.

Key Question 2

What HMIS activities have been supported in your country? What current priorities will be supported with this MOP funding?

Supporting Data

Figure A53. HMIS-Supported Activities

Intervention	PMI-Funded? (X)			Does Global Fund plan to fund this? (X)	Does another donor plan to fund this? (X)
	FY 18	FY 19	FY 20		
Central Level					
Register, tools (e.g. checklists, indicator glossary), job aids (design, indicators, definition of data elements, data dictionary, system support)			(X)	(X)	(X)
Data quality assessments (separate from supervision – funding for travel to lower levels)	(X)	(X)	(X)	(X)	(X)
Program monitoring and technical assistance (funding for travel to lower levels)	(X)	(X)	(X)	(X)	
Training (funding for central level to conduct training at lower levels, capacity building, i.e. on the job training for central level staff)	(X)	(X)	(X)	(X)	(X)
Human Resources (secondment of person in NMCP for SM&E, office/team for SM&E)			(X)	(X)	(X)
Data Use (analysis, interpretation, visualization (dashboards, bulletins, dissemination/feedback to lower levels, decision-making)	(X)	(X)	(X)	(X)	(X)
Policy guidelines and coordination (updating policies, guidelines, supporting sub-committee meetings, supporting participation in sub-committee meetings)	(X)	(X)	(X)	(X)	(X)
External relations/Communications/Outreach (support travel to international meetings and publications)	(X)	(X)	(X)	(X)	(X)
Support to annual operational plans for national malaria program	(X)	(X)	(X)	(X)	(X)
Desk review to catch “logic errors system” (provide TA to catch logic errors)					(X)
Admin 1 Level (Region/Province/State). PMI supports activities in all 13 regions while Global Fund supports activities in all 13 regions.					
Registers (warehousing, printing, distribution)		(X)	(X)	(X)	(X)

Intervention	PMI-Funded? (X)			Does Global Fund plan to fund this? (X)	Does another donor plan to fund this? (X)
	FY 18	FY 19	FY 20		
Data quality assessments (separate from supervision – funding for travel to lower levels)	(X)	(X)	(X)	(X)	(X)
Program monitoring and technical assistance (funding for travel to lower levels)	(X)	(X)	(X)	(X)	(X)
Training (funding for Admin 2 staff to conduct training at lower levels, capacity building (i.e. on the job training for Admin 2 level staff)	(X)	(X)	(X)	(X)	(X)
Human Resources (secondment of person for malaria SM&E, office/team for SM&E)					
Data Use (analysis, interpretation, visualization (dashboards, bulletins), dissemination/feedback to lower levels, decision-making)	(X)	(X)	(X)	(X)	(X)
Adaptation of national policy guidelines and coordination (adapting policies, guidelines, supporting sub-committee meetings, supporting participation in sub-committee meetings)					
Adaptation of checklists and job-aides					(X)
Participation in national meetings (support for travel costs)	(X)	(X)	(X)	(X)	(X)
Support to Annual Operational Plans for Admin 1 Malaria Program					
Admin 2 Level (District)					
Data entry, summary, and transmission (training, re-training, computers, internet, tools)				(X)	(X)
Supervision (training, traveling, supervision tools/checklists, create/design system for organized/methodical supervision)	(X)	(X)	(X)	(X)	(X)
Data validation (data validation activities before monthly data submission - organize health facilities)					
Monthly/Quarterly data quality review meetings (venue, meeting support)	(X)	(X)	(X)	(X)	(X)

Intervention	PMI-Funded? (X)			Does Global Fund plan to fund this? (X)	Does another donor plan to fund this? (X)
	FY 18	FY 19	FY 20		
Data Use (analysis, interpretation, visualization (i.e. dashboards), dissemination/feedback to facilities, decision-making)					(X)
Human Resources (secondment of person for malaria SM&E, office/team for SM&E)					
Annual planning with Admin 1 (support travel)					
Facility Level					
Data collection/entry, summary, and transmission (training, re-training, computers, internet, tools)					
Supervision of CHWs (training, traveling, administering supervision tools/checklists of community health workers)					(X)
Data use (analysis, interpretation, visualization (dashboards), dissemination/feedback to CHWs, decision-making)					
Monthly/Quarterly data quality review meetings(support for travel)					
Community Level					
Data collection/entry and transmission (training, re-training, tools	(X)	(X)	(X)	(X)	(X)
Data use (analysis, interpretation, decision-making)					
Monthly/quarterly data quality review meetings (support for travel)					

Conclusion

There is robust support at the central level and that support is expected to be strengthened further through the workstream A collaboration between PMI, BMGF and Global Fund. Quantity, frequency, and type of support decreases significantly as we move down the health pyramid to almost nonexistent at the facility level and very limited at the community level. Support at the subnational level is limited by availability of funds and even more so by the deteriorating security situation. To begin to address this challenge, funds have been earmarked to support the community level in FY 20. It is also expected that the Foreign Service National malaria data specialist would spend at least 50 percent of their time seconded to the NMCP SM&E team.

Key Question 3

What are the outcomes of HMIS strengthening efforts?

Supporting Data

Figure A54. HMIS Strengthening Efforts

		2017	2018
Timeliness	% of reports received on time	80^	69*^
Completeness	“Confirmed malaria cases for children under 5 years of age" was reported in X% of facility-months	78.0	77.8
Accuracy*	Populate with most recent DQA data	76.2%	n/a

*Mean Accuracy for six indicators assessed
^From 2017 DQA
*^ From HMIS (indicator not routinely calculated before 2018)

Conclusion

Timeliness of data entry for reports into the national HMIS is weak because of the time it takes for paper reports from distant health facilities to arrive at the district. More needs to be done to improve completeness especially as pertains to malaria data. Since data relevant for malaria comes from nine different forms, it would be helpful to identify key tracer variables to track malaria data completeness more accurately. This would be explored by CHAI as part of the surveillance system assessment funded by BMGF under workstream A and recommendations would be implemented with FY 20 funds.

Key Question 4

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

The 2019 health sector strike (May - November) resulted in the non-availability of routine and key intervention (campaign) data including SMC and mass ITN distribution for most of 2019. Negotiations are ongoing between the government and unions and it is hoped (but not certain) that data from this time will be retrospectively submitted. Even if the data are eventually provided it is likely that the quality of this data will be compromised and it would take several months to clean and make sense of the data.

Conclusion

PMI in coordination with the Global Fund plans to provide assistance to the NMCP in closely examining data that covers the 2019 health sector strike period, if and when that data becomes available, and work to ensure the quality of that data to the extent possible. If these data become available and after they have been reviewed and hopefully deemed reliable and/or usable, they will provide more information with which to prioritize activities for FY 2020.

3.C. SOCIAL AND BEHAVIORAL CHANGE (SBC)

NMCP Objective

SBC falls under Objective 3 of the NMCP's 2016-2020 National Strategic Plan, which emphasizes advocacy, social mobilization, and behavior change communication to strengthen the capacity of the NMCP to effectively manage the fight against malaria.

NMCP Approach

The National 2016-2020 Communication Strategy aims to improve the population's malaria knowledge, care-seeking practices, ITN use, and uptake of SMC and IPTp. Activities to advance these goals include community advocacy, interpersonal communication with CHWs, development of new SBC tools, and mass communication campaigns.

PMI Objective in Support of NMCP

- Key areas of PMI support for SBC have included revising national malaria SBC strategies; building country capacities in SBC; and implementing SBC to improve intervention uptake.
- PMI will continue working with the NMCP communication unit and will focus on tailored messaging to address barriers impeding effective malaria interventions.
- PMI, in collaboration with the Global Fund, will support the NMCP to hold a stand-alone World Malaria Day.
- PMI will continue to support mass communication campaigns that promote ITN use, IPTp, and early care-seeking behavior, targeting social norms of early ANC, perceived risk of malaria infection, and early care-seeking response efficacy. As in previous years, campaigns will continue via a variety of channels including short television spots, radio messages, and billboards. Follow up monitoring will be conducted to determine response efficacy to care seeking and social norms for early ANC attendance and SP administration.

PMI-Supported Recent Progress *(Past 12-18 Months)*

- School-based sensitization campaign with debates on malaria prevention on television with schoolchildren
- Radio and TV spots on IPTp and ITN use produced in French and local languages. A total of 6,148 spots were broadcast across 23 radio channels and four television channels.
- World malaria day standalone celebration in Bobo Dioulasso with the US Ambassador and other major donors (Global Fund, WHO, World Bank) in attendance
- Project-supported SBC activities and community sessions reached 287,404 people
- Implementation of an endline TRaC survey to assess knowledge, attitudes and practices related to malaria.

The health sector strike and the insecurity in 2019 impacted the ability to conduct SBC activities in some locations. This situation has also affected access to routine data from the health system to track progress.

PMI-Supported Planned Activities *(Next 12-18 Months Supported by Currently Available Funds)*

- Tracking Results Continuously (TraC) survey finalization
- SBC to support SMC and IRS, pre-referral treatment with rectal artesunate activities
- SBC mass campaign with tailored messages targeting barriers that are impeding effective behavior change for IPTp3 uptake ,ITN use, early care seeking for children under 5 years of age and pregnant women.

PMI Goal

Through the use of social and behavior change interventions and in alignment with a country's national malaria control communication strategy, PMI supports the uptake and correct and consistent use of malaria interventions, thereby improving the overall quality of malaria control efforts that will contribute to reductions in malaria morbidity and mortality.

Do you propose expanding, contracting, or changing any SBC activities? If so, why and what data did you use to arrive at that conclusion?

PMI has allocated a total of $700,000 FY 2020 funds to support SBC activities which is an expansion from previous years. Of the allocated resources, $200,000 would specifically address improving SMC implementation and uptake based on program data (spike in cases two weeks after SMC passage) suggesting that second and third doses of SPAQ are not properly administered. The remaining $500,000 will be used to support the NMCP to improve integrated case management and prevention activities through mass communication campaigns and tailored SBC messaging addressing barriers to IPTp3 uptake, ITN use, early care seeking for children under 5 years of age and pregnant women. The overall scope of SBC activities are generally similar to previous years with an added focus on community health.

Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Key Question 1

What behaviors is PMI proposing to prioritize through its SBC programming? Will support be geographically targeted or at national scale? What data support this prioritization?

Supporting Data

Please see the ITN, case management, SMC, and MIP sections for supporting data. SMC activities cover 12 health districts.

Conclusion

Figure A55. Prioritized Behaviors with FY2020 Funds

Behavior	Target Population	Geographic Focus	Justification
Use of ITN	Children under five and pregnant women	National	54% Children under five years old and 58% of pregnant women slept under an ITN the previous night according to the 2017 MIS
Uptake of IPTp3	Pregnant women	National	Per the 2017 MIS, 54% of women received three or more doses of IPTp during their last pregnancy in the last two years. In 2014, 22% of pregnant women took at least 3 doses of SP under direct CHW observation during ANC
Prompt care seeking for children under five	Caretakers	National with focus in Sahel Region and other high burden regions	74% of children under five years of age with fever in the last two weeks sought treatment or advice
Adherence to Case Management Guidelines	Health providers	National	79% of children received an ACT among children under five years old with fever in the last two weeks who received any antimalarial drugs
SMC uptake	Parents and guardians of children under 5	PMI-supported SMC districts	There is evidence of increased cases two weeks after implementation of one round of SMC. One hypothesis is that this could be due to non-adherence to the second or third dose. Funds allocated will be used to prioritize messaging to parents regarding the administration of doses two and three.

Key Question 2

Given the priority behaviors identified, what data are available to better understand the factors influencing low uptake? What are the behavioral determinants of the prioritized behaviors? Are there gaps in understanding the barriers to uptake?

Supporting Data

Figure A56. Summary of Determinants and Gaps for FY2020 Prioritized Behaviors

Behavior	Key Facilitators	Key Barriers	Knowledge Gaps
Adherence to case management guidelines	Unknown	Unknown	We know that there is a gap in behavior of healthcare workers not following the case management guidelines (See case management section for details), but there is an information gap regarding the predictors of behavior
Prompt early care	Unknown	Unknown	We know that there is a gap in early care seeking and that this gap varies by geographic area. There is a knowledge gap regarding the predictors of early care seeking.
IPTp uptake	• Availability of SP at facility level • Targeted communication on importance of ANC and IPTp • Better access to IPTp by pushing out to the community level • Training of health personnel	Late start to ANC visits	There is not a significant knowledge gap for this behavior.
Use of ITNs	Availability (access)		PMI will have the opportunity to learn more about ITN use after the 2019 mass distribution campaign during the 2020 DHS

Conclusion

TraC survey results will provide more information about behavior change and the key determinants. Also a DHS including a malaria component will be conducted in 2020 during the peak malaria season. The NMCP is conducting a stratification for a mix of interventions, with the technical support of WHO and the Gates Foundation final results are expected by January 2020 and will be used to define the package of interventions needed at a regional/district level.

Key Question 3

What activities are needed to bolster the country's capacity for SBC? Are these activities needed at the national or sub-national level?

Supporting Data

As had been described in the previous sections, there is information about behavior, but not predictors of those behaviors in Burkina Faso. To bolster the country's capacity for SBC, further

information is needed. Furthermore, most of the SBC strategy in Burkina Faso has focused on mass communication activities, the impact of which are difficult to measure.

Conclusion

PMI plans to reinforce the CHWs and the other care providers' capacity to improve the case management adherence for severe and simple malaria cases and IPTp uptake in the community. Based on surveys (TraC, DHS) and results from the malaria risk stratification exercise to determine optimal mix of interventions, PMI along with other donors will continue to provide support tailored messaging for appropriate ITNs use and prompt care seeking.

3.D. PROGRAM EVALUATION AND OPERATIONAL RESEARCH

NMCP objective
● To generate quality data on malaria in Burkina Faso ● To ensure the availability of data, including survey data, at opportune times
NMCP approach
Research activities will be led by research centers in collaboration with the NMCP and will focus on epidemiology, malaria burden, SMC, ITNs, therapeutic efficacy of antimalarial drugs and entomologic resistance. Support for research will be provided to regions and health districts. Additionally, agreements will be signed between the NMCP and research entities to ensure timely data.
PMI objective, in support of NMCP
PMI supports the objective of the NMCP for operational research.
PMI-supported recent progress (past ~12-18 months)
There has been one PMI-supported operational research study in Burkina Faso that sought to determine whether utilization of CHWs for delivery of IPTp in three districts can increase coverage of three or more IPTp doses compared to IPTp delivery only at ANC, and without having a negative impact on ANC attendance. This study took place between 2016 and 2018 and focused on rural areas, which was determined based on data gathered from the 2010 DHS indicating that around 44 percent of rural women never attend ANC during their pregnancy. The study was core-funded although some country-level funds were included in FY 2016 and FY 2017 to help support this study. Preliminary results of the study showed an increased uptake of IPTp in the intervention areas. The evidence has resulted in a decision by PMI to continue to support community IPTp in the areas where the study took place.

PMI-supported planned activities (next ~12-18 months, supported by currently available funds)

- With reprogrammed FY 19 funding, PMI plans to conduct an evaluation of the impact of IRS in the three districts where the activity is in place since 2018 and is scheduled to end next year due to lack of funding.
- PMI is also supporting the durability monitoring portion for the evaluation of the next generation ITNs as part of the New Nets Project.

PMI Goal

PMI will conduct OR/PE that helps: to evaluate coverage of population at-risk, quality of intervention(s), and efficiency in intervention delivery, or study reducing remaining malaria transmission and disease burden, test effectiveness of new or evolved priority interventions and strategies, or explore new metrics and mechanisms to assess the impact of interventions.

Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Do you propose expanding, contracting, or changing any program evaluation and operational research activities? If so, why and what data did you use to arrive at that conclusion?

There are no current plans for PMI-supported operational research or program evaluation activities in FY 2020.

Please see Table 2 for a detailed list of proposed activities with FY 2020 funding.

Key Question 1

Have technical challenges or operational bottlenecks that require operations research or program evaluation been identified in consultation with the NMCP? How have they been prioritized?

Supporting Data

The NMCP has identified the following as current research priorities in the 2016-2020 strategic plan:

- Feasibility and impact of three days of supervised doses of SP-AQ during SMC
- Potential impact of providing SMC to children 5-10 years of age
- Investigation of "bounce back" in cases after two weeks of SMC campaign
- Determinants of preventive behaviors for malaria

Figure A57. PE/OR Currently Conducted in Burkina Faso with USG, GF, Multilaterals or Other Major Donors.

Source of Funding	Implementing institution	Research Question/Topic	Current status/timeline
e.g. NIH ICEMR, GF UNITAID, MMV, IVCC, WHO, BMGF			
BMGF	WHO	Stratification of interventions	Underway (as of December 2019)
BMGF	CHAI	Surveillance system evaluation	Underway (as of December 2019)
PMI	IMC	TraC survey	Underway (as of December 2019)
Malaria Consortium	Malaria consortium	Feasibility of five rounds of SMC in zones with longer transmission season.	Completed October 2019
Malaria Consortium	Malaria consortium	Feasibility of expansion of SMC to cover children 5 to 10 years old.	Underway (as of December 2019)

Conclusion

There are several operational bottlenecks and needs for evidence on interventions in Burkina Faso that could help to break the trend in growing incidence in Burkina Faso.

Key Question 2

In the technical areas covered above, are there specific issues in any of the intervention areas that merit further exploration, in anticipation of establishing intervention strategies that are or could become available in the future that could be applied?

Supporting Data

As described in the SMC section, there are questions about increased cases in the two weeks after the SMC campaigns. Further investigation into the potential predictors of this and how to optimize SMC implementation to have the greatest impact is a priority for the NMCP and PMI.

Additionally, as a high burden to high impact country, the NMCP is in the process of working with a team of modelers to generate insights into potential stratified intervention mixes that could inform programming. It is anticipated that the results of this desk exercise could generate questions that could be answered using OR and/or program evaluation.

Conclusion

There are currently no PMI funds available to support OR in Burkina Faso at this time, but PMI is available to provide technical assistance to the prioritization of activities and to OR projects supported by other financial and technical partners.

Key Question 3

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

N/A

Conclusion

While there is a need for more evidence to inform programming decisions in Burkina Faso, the current budget does not allow for MOP-funded OR or PE in Burkina Faso.

3.E. OTHER HEALTH SYSTEMS STRENGTHENING

NMCP objective
To strengthen the capacity of communication, commodity security, evaluation and research, response to epidemics and emergencies, and NMCP program management.
NMCP approach
The NMCP strives to strengthen the capacity of communication, commodity security, evaluation and research, response to epidemics and emergencies, and NMCP program management. Capacity building objectives will be obtained through a variety of approaches including trainings, workshops, advocacy, procurement, and evaluation
PMI objective, in support of NMCP Infrastructure
N/A
PMI-supported recent progress (past ~12-18 months)
Over the past 18 months, PMI has not supported other capacity building outside that proposed within specific technical areas.
PMI-supported planned activities (next ~12-18 months, supported by currently available funds)
Support for a cohort of 15 malaria-focused participants in intermediate FETP to initially cover 4 regions (3 participants per region) and three participants from the central level.

PMI Goal
Ensure coverage of all 13 health regions as well as the central level in order to improve data collection, analysis, visualization, and interpretation at all levels of the health system and enhance data use for strategic decision making.

Key Question 1

How can Burkina Faso improve data quality in order to use data more routinely for decision making?

Supporting Data

Ensure coverage of all 13 health regions as well as the central level in order to improve data collection, analysis, visualization, and interpretation at all levels of the health system and enhance data use for strategic decision making.

Conclusion

Full coverage of the country will take three years. PMI plans to support a second cohort of 15 malaria-focused participants in intermediate FETP with FY 2020 funds.

Key Question 2

Are there any other considerations that impact your funding allocation in this category?

Supporting Data

N/A

Conclusion

N/A