# BURKINA FASO
# FY2015

Control of Neglected Tropical Diseases

Annual Work Plan
October 1, 2014 – September 30, 2015

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**ACRONYMS AND ABBREVIATIONS**

| | |
|---|---|
| **ALB** | : Albendazole |
| **APOC** | **:** African Programme for Onchocerciasis Control |
| **BCC** | **:** Behavior Change Communications |
| **BMT** | : Biomedical Technician |
| **CDTI** | **:** Community-Directed Treatment with IVERMECTIN |
| **CHIES** | : Center for Health Information and Epidemiological Surveillance |
| **CHSP** | : Center for Health and Social Promotion |
| **CNTD-L** | : Center for Neglected Tropical Diseases - Liverpool |
| **CSM** | **:** Community Self-Monitoring |
| **DCD** | : Disease Control Directorate |
| **DFATD** | **:** Canadian Department of Foreign Affairs, Trade and Development |
| **DFID** | **:** Department for International Development |
| **DQA** | : Data Quality Assessment |
| **DSA** | **:** Disease Specific Assessment |
| **FDC** | : Fondation pour le Développement Communautaire (Foundation for Community Development) |
| **FHI360** | : Family Health International 360 |
| **FY** | : Fiscal Year |
| **GAELF** | : Global Alliance to Eliminate Lymphatic Filariasis |
| **GDPML** | **:** General Directorate of Pharmacies, Medicines and Laboratories |
| **GET 2020** | : Alliance for the Global Elimination of Blinding Trachoma by 2020 |
| **GPS** | : Global Positioning System |
| **HD** | : Health District |
| **HI** | : Handicap International |
| **HKI** | : Helen Keller International |
| **ICT** | : Immunochromatographic Test |
| **IEC** | : Information, Education, Communication |
| **IVM** | : Ivermectin |
| **LF** | : Lymphatic Filariasis |
| **MCSW** | : Medical Center with Surgical Wing |
| **MDA** | : Mass Drug Administration |
| **M&E** | : Monitoring and Evaluation |
| **MOH** | : Ministry of Health |
| **NTD** | : Neglected Tropical Disease |
| **NTDP** | : Neglected Tropical Diseases Program |
| **OV** | : Onchocerciasis |
| **PC NTDs** | : Neglected Tropical Diseases targeted through Preventive Chemotherapy |
| **Pre-TAS** | **:** Pre-Transmission Assessment Survey |
| **PZQ** | : Praziquantel |
| **RHC** | : Regional Hospital Center |
| **RHD** | : Regional Health Directorate |
| **SAEs** | : Serious Adverse Events |
| **SAFE** | : Surgery, Antibiotics, Facial cleanliness and Environmental improvement |
| **SCH** | : Schistosomiasis |
| **SOP** | : Standard Operational Procedures |
| **STH** | **:** Soil-Transmitted Helminthes |

**TA** **:** Technical Assistance
**TAS** **:** Transmission Assessment Survey
**TEC** : Trachoma Expert Committee
**TF** : Trachomatous Inflammation Follicular
**TIPAC** : Tool for Integrated Planning and Costing
**TT** : Trachomatous Trichiasis
**UHC** : University Hospital Center
**USAID** : United States Agency for International Development
**WASH** : Water, Sanitation, and Hygiene
**WA-WASH** **:** West African Water, Sanitation and Hygiene Project
**WHO** : World Health Organization

**Executive Summary**

Burkina Faso's Master Plan (2012-2016) for neglected tropical disease (NTD) was adopted in January 2013 and has a number of activities to be carried out over a 5-year period as part of the efforts to combat NTDs through the End in Africa project of the United States Agency for International Development (USAID) NTD Program. This work plan for fiscal year (FY) 2015 is prepared by the national NTD Program (NTDP) of the Ministry of Health (MOH) of Burkina Faso with technical support from Helen Keller International (HKI) and submitted through Family Health International (FHI 360) to the USAID NTDP for approval. A number of activities relating to mass drug administration (MDA), monitoring and evaluation (M&E) including disease specific assessment (DSAs), and other cross-cutting activities including behaviour change communication (BCC) are planned in FY2015 to enable the MOH of Burkina Faso achieve the overall objectives of control/elimination of the 5 NTDs targeted through preventive chemotherapy (PC NTDs): lymphatic filariasis (LF); schistosomiasis (SCH); onchocerciasis (OV); trachoma; and soil-transmitted helminthes (STH).

The following MDA activities will be implemented in FY2015 by the different disease units under the NTD Coordination (see Appendix 1) to achieve the annual objectives:

1. MDA with ivermectin (IVM) and albendazole (ALB) for LF elimination will target 30 health districts (HDs)[1];
2. MDA with praziquantel (PZQ) for SCH will be carried out in 26 HDs[2];
3. OV treatment with IVM will target 6 HDs[3];
4. Trachoma treatment with oral azithromycin and 1% tetracycline eye ointment will take place in 7 HDs[4]; and,
5. STH control efforts with ALB will cover 42 endemic HDs, where LF MDA or SCH MDA activities are to be implemented in FY2015[5].

In addition to MDA, M&E activities will be implemented to monitor progress and evaluate the impact of the treatments administered. The following activities will be implemented by each program:

<u>Lymphatic Filariasis</u>

1. Pre-transmission assessment survey (pre-TAS) in 11 HDs (using 15 sentinel sites (SS) and spot-check sites (SC)) to determine whether or not the 11 HDs are eligible for Transmission Assessment Surveys (TAS) - 10 SS/SCS with END in Africa project support and 5 SS/SCS with Center for NTDs-Liverpool (CNTD-L) support;

[1] Total of 30 HDs will be treated for LF elimination in FY2015. 21 of the 30 HDs will be treated uniquely with USAID funding provided through the END in Africa project. Another 5 HDs will conduct biannual MDA for LF with 1 of these MDAs financed by the USAID END in Africa project and the other by the Center for NTDs-Liverpool (CNTD-L). The remaining 4 HDs will be treated with funding uniquely from CNTD-L.

[2] All 26 HDs will be treated with USAID funding provided through the END in Africa project.

[3] Total of 6 HDs require MDA for OV. 4 HDs will be treated with financial support from the END in Africa project; and the other 2 HDs will be treated with funding from Sightsavers.

[4] 5 HDs require MDA based on their most recent prevalence results and will all be treated with funding from the END in Africa project. There are 6 HDs that will undergo sub-district level surveys, either because they had baseline trachomatous inflammation follicular (TF) prevalence between 5% and9.9% at baseline (as per recommendations of the Global Elimination of Blinding Trachoma by 2020 (GET 2020) Alliance and the Trachoma Expert Committee (TEC)), or have already had district-level impact assessments and now require sub-district level surveys according to World Health Organization (WHO) guidelines. The NTDP is planning for MDAs in an additional 2 HDs based on what they expect from the results of these subdistrict level surveys.

[5] A total of 30 of these HDs will be treated with IVM+ALB (LF MDA) and 12 will be treated with PZQ+ALB (SCH MDA integrated with STH MDA). Of these 42 HDs, 38 will be treated with support from the END in Africa project, either through the LF MDA (IVM+ALB) or the SCH MDA (PZQ+ALB). The other 4 HDs will be treated via CNTD-L support for LF.

2. TAS in 4 HDs to determine if LF MDA can be stopped (USAID/END in Africa project will support procurement of the immunochromatographic test (ICT) cards, while the Government of Burkina Faso will support the implementation costs of the TAS); and,
3. Post-MDA surveillance for LF in 13 HDs (TAS I (in 7 HDs) and TAS II (in 6 HDs)) to assess whether there has been a recrudescence in transmission after MDA was stopped 2 years ago (TAS 1) and 4 years ago (TAS II); USAID/END in Africa project will support post-MDA surveillance in 10 of the 13 HDs.

Trachoma

As part of trachoma elimination efforts, the following M&E activities are planned:

1. District-level impact studies to evaluate MDA with azithromycin will be conducted in 4 HDs following their third round of MDA per WHO recommendations. These HDs include Dafra, Dandé, Karangasso Vigué, and Signonghin;
2. Sub-district level surveys in 4 HDs where baseline mapping revealed a TF prevalence between 5% and 9.9% among children ages 1-9 years to determine whether sub-district-level treatment is necessary or whether the elimination target has been reached[6];

Onchocerciasis

Coverage surveys and community self-monitoring (CSM) of community-directed treatment with ivermectin (CDTI) will be conducted in accordance with APOC recommendations.

Cross-Cutting Activities

In addition to the specific activities noted above for FY2015, other cross-cutting activities will contribute towards achieving the annual objectives that the program has set including:

3. Strengthening coordination and partnership with the NTDP via support for operations, meetings, workshops, distribution of reports, and an annual review;
4. Strengthening performance of the NTDP by improving programmatic and geographic coverage during NTD MDAs (including training for actors involved in MDA distribution, supervising MDA implementation, supplying and administering drugs, reproducing data collection tools, and holding integrated review meetings);
5. Implementing specific monitoring of activities at different implementation levels;
6. Implementing BCC activities among populations in endemic areas using specific information, education and communication (IEC) materials on NTDs (support for launching of NTD campaign, advocacy, information and awareness meetings, and media campaigns); and,
7. Requesting technical assistance (TAs) based on the requirements and limitations of the NTDP to improve the quality of NTDP activities.

[6] When HDs have a baseline prevalence between ≥ 5% and < 10% TF among children 1-9 years (commonly called "5-9.9% HDs"), per WHO guidelines, it is necessary to re-survey at the sub-district level in order to determine whether any sub-districts require MDA, since the elimination target for active trachoma is a prevalence <5% at the sub-district level as well as the district level. As these surveys are expensive, the 4 HDs with the highest baseline prevalence in this category, Barsalogo (9.75%), Kaya (9.43%), Gayeri (7.55%) and Fada (7.50%), will be assessed first, as they are more likely to require sub-district MDAs than those HDs with lower baseline prevalence. There are 15 such HDs in this category.

**COUNTRY OVERVIEW**

Located in the heart of West Africa, Burkina Faso is a land-locked country with a geographic area of 274,200 square kilometers. It is bordered on the north and west by Mali, on the east by Niger and on the south by Benin, Togo, Ghana and Côte d'Ivoire. Burkina Faso has a tropical climate and 2 main seasons: a dry season and a rainy season. Three rivers drain the country - the Mouhoun, Nazinon and Nakambé.

According to the 2006 General Population and Housing Census, Burkina Faso's population was 14,017,262, with a population density of approximately 51.8 inhabitants per square kilometer. The 2015 population is projected and estimated at 18,450,494 using an annual population growth rate of 3.1%. Burkina Faso is divided administratively into 13 regions, 45 provinces, 350 departments, 351 communes (49 urban and 302 rural) and 8,228 villages. There are 13 Regional Health Directorates (RHDs), 63 health districts (HDs)[7], and 1,285 Centers for Health and Social Promotion (CHSPs). Currently geographical areas that can be considered as clearly defined sub-districts have not been identified either administratively or within the health system but there is a process underway to determine such geographical areas that can be considered sub-districts.

In addition to the United States Agency for International Development (USAID), the following donors are supporting efforts to combat neglected tropical diseases (NTDs) in Burkina Faso:

1. **Burkinabé government:** Provides support for lymphatic filariasis (LF) mass drug administration (MDA) campaigns, LF impact assessment in the Centre and Sahel regions, and provides significant logistical support (vehicles) during MDAs and monitoring and evaluation (M&E) activities. The government also procures the 1% tetracycline eye ointment used for trachoma elimination efforts in all HDs eligible for MDA. This contribution is estimated at approximately 200 million FCFA (approximately US$ 400,000) per year. In addition, financial contribution is provided by management committees at the CHSP level on a case by case basis if there are gaps at the operational level. This funding is not accessible in all HDs and difficult to evaluate in terms of monetary value. These funds are also generally used to provide financial incentives to community drug distributors (CDDs) during MDAs.
2. **Sightsavers:** Provides financial support for efforts to combat trachoma morbidity and implement Community-Directed Treatment with Ivermectin (CDTI) for the elimination of onchocerciasis (OV) in the Cascades region. The donation is approximately 60 million FCFA (US$ 127,000) per year for both diseases.
3. **The Department for International Development (DFID) via the** Center for Neglected Tropical Diseases - Liverpool **(CNTD–L)**: Provides financial support (approximately 80 million FCFA or US$165,000 per year) for LF elimination activities: pre-transmission assessment surveys (pre-TAS), transmission assessment surveys (TAS), post-MDA surveillance, and MDAs. This support is provided on a priority basis to the South-West and Center-South regions, the Zabré HD, and the national coordination.
4. **Fondation l'Occitane via Helen Keller International (HKI)**: Provides financial support for trachomatous trichiasis (TT) surgery in 2 HDs (Koudougou and Sapouy) in the Centre-Ouest region (approximately US$80,000 per year), though this funding will end in October 2014).
5. **Canadian Department of Foreign Affairs, Trade and Development (DFATD) via HKI**: Provides financial support for integrated deworming and vitamin A supplementation for children <5 years of age in the Sahel and Est regions.

[7] Officially, there are 70 HD; however, practically, 7 HDs are not functional. The 63 HDs used here are the old demarcation which covers the areas of all 70 new HDs geographically.

USAID support for the integrated Neglected Tropical Diseases Program (NTDP) in Burkina Faso started in 2007 through USAID's NTDP with support for implementation of the LF, schistosomiasis (SCH), soil transmitted helminthes (STH), trachoma and OV programs. From 2007 to 2011, the USAID support was provided by the NTD Control Program managed by Research Triangle Institute (RTI) International through Schistosomiasis Control Initiative (SCI). During this period, individual disease programs were integrated under one overarching NTDP Coordination, baseline mapping for trachoma was completed, full geographic scale-up of MDA was achieved (treatments were extended to all endemic HDs for the 5 NTDs), and some M&E activities were implemented.

Since 2011, USAID support in Burkina Faso has been provided by the USAID/End in Africa Project managed by Family Health International 360 (FHI360) through HKI. The renewal of funding from USAID through the END in Africa Project in 2011 has enabled the NTDP to continue, expand and improve on the following activities: financial support to carry out MDAs for the control/elimination of the 5 NTDs targeted through preventive chemotherapy (PC NTDs), M&E (impact assessments, pre-TAS, TAS and post-MDA surveillance), and capacity building (conducting MDA and post-endemic surveillance activities). In addition, the END in Africa Project has provided technical assistance (TA) in the form of a review of the SCH strategy, an action plan for trachoma elimination, logistical management, and use of the tool for integrated planning and costing (TIPAC).

**National NTD Program Overview**

A brief overview of the diseases and the strategies used to achieve the objectives of controlling and eliminating PC NTDs are outlined below:

- LF was found to be endemic in all 63 HDs following the completion of mapping in 2002. The national LF elimination program was created in 2001 with the aim of eliminating LF as a public health problem by 2020 using the following strategies: MDA; treatment of LF complications (hydrocele and lymphedema); advocacy and behaviour change communication (BCC) using information, education and communication (IEC) materials; vector control efforts; surveillance; and capacity building.

- OV is presently endemic in 6 HDs in the Cascades and Sud-Ouest regions. The National OV Program was established in 1991 after the closing of the Onchocerciasis Control Program with the aim of eliminating OV by 2025 using CDTI, BCC, advocacy, epidemiological and entomological surveillance, vector control efforts and capacity building.

- SCH and STH are endemic in all 63 HDs in Burkina Faso. The national objective is to eliminate SCH and STH as a public health problem by 2020. The national SCH/STH program started in 2004 with financial support from SCI and started receiving financial support from the USAID NTDP in 2007. SCH and STH strategies include: MDA, environmental sanitation, BCC, advocacy, surveillance and capacity building.

- Trachoma is endemic in 30 HDs. The National Blindness Prevention Program was established in 2002 and has the goal of eliminating blinding trachoma as a public health problem by 2020 using the SAFE (Surgery, Antibiotics, Facial cleanliness and Environmental improvements) strategy, M&E, BCC, advocacy and capacity building.

The national NTDP in Burkina Faso has started the process of integrating strategies for the

control/elimination of NTDs such as trachoma, SCH and STH with the water, sanitation and hygiene (WASH) strategy with the aim of accelerating efforts to meet its control/elimination goals. To start the process there has been an exploratory mission led by FHI360 WASH Plus in May 2014. The objective of this mission was to identify opportunities for integrating NTD and WASH activities, and determine the feasibility of integrating NTD and WASH activities in Burkina Faso. The integrated NTD/WASH activities will focus on BCC, community mobilization and sensitization, and advocacy for additional resources. Following this mission, promotion and advocacy for WASH activities for trachoma and SCH elimination will be carried out. If additional resources can be found, the following activities will also be implemented: meetings with different stakeholders to gain support for integrated BCC and advocacy activities and to secure resources for implementing these activities; a workshop to develop an operational plan for BCC and advocacy activities with trachoma and SCH stakeholders at the operational level (i.e. the regional and district levels), as all previous discussions have been held at the national level only; and WASH interventions beyond BCC and advocacy, to include provision of clean water and sanitation in areas where these NTDs are endemic and problems of hygiene and sanitation are apparent.

**Table 1: Snapshot of the status of the NTDP in Burkina Faso**

| | | MAPPING GAP DETERMINATION | | | MDA GAP DETERMINATION | | | DSA NEEDS | ACHIEVEMENT |
|---|---|---|---|---|---|---|---|---|---|
| A | B | C | D | E | F | | G | H | I |
| Disease | Total No. of Districts in COUNTRY | No. of districts classified as endemic | No. of districts classified as non-endemic | No. of districts in need of initial mapping | No. of districts under a 'current MDA schedule' (prior to work plan discussions) | | No. of districts in need of MDA at any level, but MDA not yet started, or prematurely stopped (prior to work plan discussions) | No. of districts requiring DSA | No. of districts where criteria for stopping district-level MDA has been achieved |
| | | | | | USAID-funded | Others | | | |
| LF | 63 | 63 | 0 | 0 | 25[a] | 9[a] | 0 | Pre-TAS- 11 HDs<br>TAS- 4 HDs)<br>TAS I - 7 DS<br>TAS II- 6 DS | 33 |
| OV | | 6 | 57 | 0 | 4 | 2[b] | 0 | 0 | 0 |
| SCH | | 63 | 0 | 0 | 63 | 0 | 0 | 0 | 0 |
| STH | | 63 | 0 | 0 | 58[c] | 9[a] | 0 | 0 | 0 |
| Trachoma | | 30[d] | 33 | 0 | 5[e] | 0 | 0 | 8[f] | 25 |

Notes:

[a] Total of 30 HDs will be treated for LF elimination in the fiscal year (FY) 2015. 21 of the 30 HDs will be treated uniquely with USAID funding provided through the END in Africa project. 4 HDs in the Sud-Ouest region will conduct biannual MDA for LF with 1 of these MDAs financed by the USAID END in Africa project and the other by CNTD-L. The remaining 5 HDs will be treated with funding uniquely from CNTD-L.

[b] Funded by Sightsavers.

[c] All HDs are currently covered by either LF MDA (since albendazole (ALB) is used for LF treatment) or by adding ALB to SCH MDA. Please refer to the Note (a) above, 25 HDs are covered by LF MDA with USAID support

(including 4 HDs in SO supported jointly by USAID and CNTD-L). In 33 HDs where LF MDA has been stopped, annual or biennial ALB treatment is conducted depending on the SCH treatment schedule.

[d] 30 HDs had a baseline prevalence of trachomatous inflammation follicular (TF) among children 1-9 years of age ≥ 10%, warranting district-wide MDA. 15 other HDs had prevalence between 5% and 9.9% at baseline, and although district-level MDA is not warranted, sub-district level surveys are required to identify sub-districts that have to be treated as district level and sub-district level TF prevalence among children 1-9 years old should be <5%.

[e] Only 5 HDs currently require district-level MDA. Sub-district-level surveys as recommended by the Global Elimination of Blinding Trachoma by 2020 (GET2020) alliance and the Trachoma Expert Committee (TEC) will be implemented in FY2015 in 4 HDs (with baseline TF prevalence between 5% and 9.9%). Sub-district level treatment may be required depending on the results; the National NTDP believes 2 additional HDs will require MDA at subdistrict level.

[f] Sub-district level surveys are planned in 4 HDs that had a baseline prevalence between 5% and 9.9%; according to WHO guidelines, they should undergo sub-district level surveys to determine whether sub-district MDA is required; Additionally, 4 HDs (Karangasso Vigué, Dafra, Dandé and Signonghin) are scheduled for district-wide impact assessment after 3 rounds of MDA,. All will be funded through the END in Africa project.

**Goals/Deliverables for the year 2015**

**General objective**

To achieve the following treatment coverage for each MDA conducted for the control/elimination of the PC NTDs: at least 65% epidemiological coverage for LF MDA with ivermectin (IVM) + ALB; 80% program coverage for SCH MDA with PZQ and/or ALB (for SCH and STH MDA); 100% program coverage for trachoma MDA with azithromycin + 1% tetracycline ointment; and 100% geographic coverage for all PC NTD treatment campaigns. In addition, the National NTDP aims to implement disease-specific assessments (DSAs) where warranted to determine whether HDs need to continue MDA or whether HDs have met World Health Organization (WHO) stop-MDA criteria and can now transition into post-MDA surveillance activities.

**Specific objectives**

The following specific objectives of the NTDP for FY2015 will be carried out uniquely with USAID support only:

1. Treat 3,452,055 people in 25 HDs against LF[8].
2. Treat 5,033,374 people in 26 HDs against SCH.
3. Treat 3,475,946 people in 37 HDs against STH.
4. Treat 142,324 people in 4 HDs against OV.
5. Treat 1,968,208 people in 5 HDs against trachoma, subject to results of impact assessment and sub-district level surveys[9].

**PLANNED ACTIVITIES**

There are no activities specifically planned to focus on gender equality and female empowerment in FY2015.

[8] 21 HDs will be uniquely supported by USAID/END in Africa project and 4 HDs will receive shared support with CNTD-L (each partner finances one of the biannual MDAs).

[9] The 5 HDs requiring MDA are either in their first or second 3-year treatment cycles. In addition, 4 HDs will be undergoing impact assessment at the sub-district level and may require MDA; the NTDP believes that 2 HDs will require subdistrict MDA in FY2015.

**Strategic planning**

The FY2015 activities of the NTDP are determined according to the program needs informed by disease prevalence and the results of impact assessments (where available) at the end of the FY2014 implementation period. For example, trachoma impact assessments from FY2014 have now demonstrated that 4 HDs no longer require MDA bringing the total number of HDs that have stopped MDA for trachoma to 25, and TAS in the Sahel region shows that MDA can be stopped in that region. However, some projections have been made for certain activities, which are dependent upon the impact evaluations to be conducted in FY2015. For example, 4 HDs (with baseline TF prevalence between 5% and 9.9%) will undergo sub-district-level evaluations on trachoma, and if any sub-district has a TF prevalence ≥10% among children ages 1-9 years, then MDA will be required in those sub-districts. Feedback from the previous campaign and supervision activities of the national NTDP, and recommendations from meetings held during FY2014 (including the WHO NTD meeting in Entebbe, the African Program for Onchocerciasis Control (APOC) meeting in Ouagadougou, FHI360 partners' meeting in Accra, GET2020, and the SCH program strategy review meeting in Burkina Faso) were taken into account in planning FY2015 program activities.

**TIPAC**

In January 2014 the NTDP and HKI staff received training from the END in Africa project (Deloitte) on TIPAC. However, the TIPAC has not yet been adopted and discussions are continuing on when to adopt this tool.

**Review/update the country's five-year NTD Master Plan**

Burkina Faso's NTDP has a 5 year NTD Master Plan which covers the period 2012-2016. Updates to this plan will be made in FY2016. However, in line with the elimination objectives for LF and blinding trachoma, in order to demonstrate that these 2 PC NTDs have been eliminated as public health problems, and to avoid recrudescence in the HDs where MDA has been stopped, the NTDP recognizes the necessity of developing surveillance plans for these 2 PC NTDs. In addition, the NTDP would like to update the available data on which it can make decisions for STH, and plans to integrate STH prevalence evaluations with TAS evaluations according to new WHO recommendations.

**Support to MOH to develop an annual work plan**

In accordance with the regular annual planning process, a workshop to develop the FY2016 work plan will take place during FY2015. All of the NTDP disease coordination units, the NTDP administrative and financial departments, the USAID NTDP, the END in Africa Project including FHI 360 and HKI representatives will participate in this workshop to plan activities for the following year.

**Additional activities**

The NTDP will require TA from its partners in order to carry out some proposed activities, due to the NTDP's limited time, financial resources and staff capacity. These activities include assistance with review of the LF elimination program the NTDP will organize in FY2015 after the special study to determine the reasons for the persistent high LF microfilaremia prevalence in some HDs in FY2014. The LF review will determine the strategies to implement in the HDs with persistent high LF microfilaremia prevalence and strategies for LF elimination in the country as a whole (for example, biannual MDA in the HDs with persistent high LF microfilaremia prevalence; revised communication and social mobilization strategies, etc.), in order to ensure the 2020 LF elimination target is met. Other TAs that will be needed include assistance with developing strategies for STH control; assistance with utilizing the WHO joint reporting and joint drug request forms; and training on data quality assessments (DQA) .

**NTD Secretariat**

The NTD secretariat in Burkina Faso in in the form of the NTDP coordination team that will receive the following support for operations:

- To assist with the daily operations of the NTDP, provide 4 laptops computers to improve the performance of the NTDP team, as 4 more personnel have been added to the NTD department, including a doctor of public health, who will coordinate M&E activities; a data manager; an assistant data manager; and an assistant coordinator for the OV program. None of these staff currently has a computer.

- Logistical support by renting vehicles to deliver drug supplies and conduct monitoring and evaluation (M&E), including trachoma impact assessments and LF impact assessments).

- Support for phone and internet service to facilitate communication among the departments and partners working on NTDs.

- Provision of office supplies and consumables to enable the NTDP reproduce data collection tools for different disease specific assessments (e.g. sentinel/spot-check site surveys, impact surveys, and post-MDA surveillance). This will also enable them to print supervisory checklists and other information used during MDA activities, as well as for general administrative usage.

- Purchase of six Global Positioning System (GPS) units for the NTDP to be used during surveys and evaluations. The GPS coordinates of survey locations collected using GPS units will provide additional data for analysis on geographical distribution of the NTDs. This will provide a tool for better programmatic decision-making. While the program currently has 6 GPS units, these are not sufficient to enable the program to use them for more than one survey at a time.

- Purchase of one video projector, a DVD player, a projector screen, and generator to be used in support of the upcoming pre-TAS and TAS surveys. They will be used to provide information to the populations targeted by the surveys. They will also be used for social mobilization activities, such as screening of the television spots on PC NTDs that are currently being produced. The NTD program currently has some of these materials; however, they are over 10 years old and not in good working condition.

**Advocacy**

The NTDP will conduct an advocacy day before the first MDA begins in each health region. These advocacy days will target political, administrative, religious and traditional authorities to encourage their commitment to NTD control/elimination activities. A total of 13 advocacy days will be organized in FY2015.

**Social Mobilization**

Burkina Faso's national NTDP had developed an integrated communication plan to encourage the population to adopt behaviors consistent with NTD control and elimination efforts. This plan was validated in November 2013 and includes activities linked directly to NTD MDA campaigns and health promotion activities. However, because it was validated after the FY2014 work plan had been approved, this integrated communication plan could not be implemented in FY2014. Cross-cutting activities according to the plan are thus planned throughout FY2015 to mobilize communities and include the production of radio and television magazine programs in French and local languages as well as the broadcast of radio and television trailers. These programs will focus on the necessity of MDA (communicated during MDA campaigns); the consequences of not being treated; and hygiene behavior to help reduce one's risk for the NTDs. Specific messages targeting women have already been developed

as part of this communication plan since women are more at-risk of developing morbidities for certain PC NTDs (i.e. trachoma) and are more often the caretakers of children, who are most at-risk for others (STH, SCH).

Awareness activities will also focus on both male and female media representatives. The activities will use national radio and television networks to ensure that broadcasts reach all villages. More specifically, this will involve:

1. The production and broadcast of 4 radio and television magazine programs in French and 7 local languages (Dioula, Mooré, Katsensa, Bissa, Dagara, Fulfuldé, and Gulmancéma) to stress the benefits associated with the correct and regular treatment for LF, OV, SCH, STH, and trachoma;
2. The production and broadcast of 2 radio and television magazine programs in French and 3 local languages (Mooré, Dioula and Fulfuldé) depicting the importance of seeking treatment at a health center for lymphedema and trachomatous trichiasis (TT);
3. The production and broadcast of 4 radio and television trailers on the benefits of correct and regular treatment for LF, OV, SCH, STH, and trachoma (in French, Mooré, Dioula and Fulfuldé);
4. Organizing a meeting with 20 media representatives (10 men and 10 women) per region (total of 260 people) to encourage their involvement in raising the population's awareness on the targeted NTDs;
5. Development of specific messages addressing the issues that will be identified during the study to determine the reasons for persistent microfilaremia in the Est, Centre-Ouest and Sud-Ouest regions in FY2014.

These awareness-raising activities will focus primarily on involving women and pre-school and school-aged children (depending on the disease) in activities to combat NTDs. This is because, in general, many of these diseases disproportionately affect these groups. For example, most TT cases are found among elderly women, and active trachoma and STH among children. The topics will be presented in the 7 local languages mentioned above, taking into consideration the ethnic population in each targeted region.

In addition, women and children will assist in carrying out grassroots communication activities. For example, they will be used as actors to give information or testimonies on their experiences with the PC NTDs and their treatment. Key messages on NTDs targeting children, mothers and schoolchildren will be broadcast and will address face and hand washing, latrine usage and treatment seeking. Finally, key messages drawn from the NTD integrated communication plan using public criers will be used for awareness-raising in gold mining sites.

**Capacity Building/Training**

In accordance with national guidelines, cascade training sessions are organized prior to implementing MDA campaigns. Training/refresher training activities supporting the MDAs will be held as follows:

Central level

A 2-day integrated training/refresher training session for trainers in Ouagadougou will be held for 33 members of the regional health directorates (RHDs) and 8 members of the NTDP team and will be conducted by the NTDP coordination. Topics will include MDA monitoring and supervision; supply chain management (SCM) and standard operating procedures (SOPs) for NTD MDAs; managing side effects; community mobilization; and completing reporting forms following MDA implementation.

Regional level

A 2-day integrated training/refresher training session for 151 staff (members of district management teams) will be held and conducted by the members of the RHDs trained at the central level. Topics will include MDA monitoring and supervision; SCM and SOPs for NTD MDAs; managing side effects; community mobilization for MDAs; and completing reporting forms following MDA implementation.

District level

A 1-day integrated training/refresher training session for 1,285 health center head nurses will be conducted by district management team members trained at the regional level. Topics will include MDA monitoring and supervision; SCM and SOPs for NTD MDAs; managing side effects; community mobilization for MDAs; and completing reports following MDA implementation.

Center for Health and Social Promotion (CHSP) level

A 1-day training/refresher training session for community drug distributors (CDDs) before each MDA campaign will be conducted by health center head nurses trained at the district level. A total of 28,822 CDDs (LF: 17,680; SCH: 5,958; trachoma: 1,640; OV: 3,544) will be trained/retrained. The topics to be addressed will include SCM and SOPs for NTD MDAs; managing side effects; community mobilization; completing community/village registers and tally sheets during MDAs.

Additional training

Twelve staff from the NTDP, Centers for Health Information and Epidemiological Surveillance (CHIES) and health center head nurses from the endemic HDs in the Cascades and Sud-Ouest regions will receive training on OV control and surveillance over a period of 21 days. This training session is necessary due to the complexity of OV surveillance and the increasing rarity of cases. Health staff at all levels need this additional training to become more effective and efficient at finding OV cases to support the NTDP's elimination targets but priority will be given to those working in endemic HDs within the 2 health regions.

The training sessions in connection with the implementation of the FY2014 MDA campaigns were carried out from February 2014 to April 2014, beginning with the training/refresher training at the central level. Each training session was held at least 4 days prior to the start of the MDA campaign in each region. The FY2015 trainings/refresher trainings are also planned for February – April 2015 and are required under the MDA implementation protocols to: 1) address issues of staff turnover within the Ministry of Health's (MOH's) departments and facilities; 2) provide an opportunity to share updates on national MDA guidelines; and 3) enable the NTDP to correct problems encountered during supervision of the last MDA and implement corrective measures to address these problems.

The beneficiaries (CDDs, Health Center Head Nurses, etc.) of the MDA trainings will be monitored by those trained at the next higher level during the cascade training. During the MDA, supervisors use checklists to monitor MDA progress and identify problems that arise during the MDAs. Assessment meetings held after each MDA will help to identify any overarching shortcomings noted in achieving the NTDP objectives and in the performance of the different actors involved. This, in turn, will be integrated into the next year's training session. In addition, quality control of the trainings is ensured through a system of supervision of trainers during the training sessions at the different levels.

**Table 2: Training Targets**

| Training Groups | Training Topics | Number to be Trained[a] | | | Number of Training days | Location of training(s) | Name other funding partner |
|---|---|---|---|---|---|---|---|
| | | New | Refresher | Total | | | |
| Regional level trainers and supervisors | MDA monitoring and supervision; SCM and SOPs for NTD MDAs; managing side effects; community mobilization; completing reports after MDA. | | | 41 | 2 | Ouagadougou | |
| District level trainers and supervisors | MDA monitoring and supervision; SCM and SOPs for NTD MDAs; managing side effects; community mobilization; completing reports after MDA. | | | 151 | 2 | Regional administrative center | |
| CHSP level trainers and supervisors | MDA monitoring and supervision; SCM and SOPs for NTD MDAs; managing side effects; community mobilization; completing reports after MDA. | | | 1,285 | 1 | Administrative center of the HDs concerned | |
| CDDs and health agents | SCM and SOP for NTD MDAs; managing side effects; community mobilization for MDAs; completing registers and tally sheets during MDAs | | | LF: 17,680 | 1 | CHSP | |
| | | | | SCH: 5,958 | 1 | CHSP | |
| | | | | Trachoma: 1,640 | 1 | CHSP | |
| | | | | OV: 3544 | 1 | CHSP | |

Note:

[a] At this time, the number of new vs. refresher training cannot be determined, as staff turnover continues throughout the year; however, the total number of persons to be trained/retrained should not significantly differ from those presented here.

**Mapping**
LF, OV, SCH, STH, and trachoma have already been mapped at the national level. No further mapping is required.

**MDA**
MDA will cover 100% of the HDs targeted for LF, OV, SCH, and trachoma. Certain HDs will not receive STH MDA in FY2015 as explained in the table notes under Table 1, as, according to the National NTDP strategy, deworming only occurs in HDs targeted for LF or SCH MDA and not as a separate activity.

Since 2009, the 4 HDs in Sud-Ouest region (Batié, Dano, Diébougou and Gaoua) have conducted twice yearly MDA for LF due to persistent high microfilaremia prevalence (≥1%) as recommended by the Global Alliance for Elimination of LF (GAELF). The first of these rounds is financially supported by the END in Africa project; and the second by CNTD-L. This will continue in FY2015. One round of MDA will be conducted in 21 HDs with END in Africa support and in 5 HDs with CNTD-L support.

For SCH, after 5 rounds of biennial treatment in the endemic HDs in Burkina Faso, impact assessments were conducted in all sentinel sites in 2013. These assessments enabled the NTDP to establish new prevalence levels in the endemic areas. Following the recommendations of the WHO expert review workshop on the Burkina Faso and Niger SCH programs held in Ouagadougou in 2012, a national SCH program review meeting of experts was held in November 2013 in Ouagadougou. According to the baseline survey data and data from other follow-up studies on SCH, the SCH treatment strategy was aligned to the WHO recommendations. These include biannual treatment in 7 HDs, annual treatment in 10 HDs and biennial treatment in 46 HDs. This new strategy will be applied in FY2015.

For OV, 6 HDs currently require MDA. Of these, 4 HDs in the Sud-Ouest region (Batié, Dano, Diébougou, and Gaoua) are treated with financial support from the END in Africa project; the remaining 2 HDs in the Cascades region (Mangodara and Banfora) are treated with funding from Sightsavers.

For trachoma, 5 HDs (Signonghin, Po, Dafra, Dandé, and Karangasso Vigue) require MDA in FY2015. Of these, 4 HDs will also undergo district-level impact assessment to determine whether MDA will be required in FY2016 and beyond. In addition, 4 HDs will undergo sub-district level surveys because TF prevalence among children 1-9 years was between 5% and 9.9% at baseline The results of these assessments may reveal sub-districts that will require MDA (see “Looking Ahead”).

For STH, all 63 HDs are endemic and are on treatment schedules either through LF (IVM+ALB) or SCH (PZQ+ALB) MDA. In FY2015, 42 of these HDs will receive MDA; 37 with financial support from the END in Africa project. Of those treated with END in Africa funding, 33 HDs will receive annual treatment, and 4 will receive biannual treatment (one of the two rounds supported by CNTD-L). Additional 5 HDs will be treated exclusively with support from CNTD-L (see “Looking Ahead”). Table 3 below is a table of target populations and frequency for planned MDAs in FY2015.

**Table 3: USAID-supported districts and estimated target populations for MDA in FY2015**

*Column definitions correspond to those found in the workbooks*

| NTD | Age groups targeted (per disease workbook instructions) | Number of rounds of distribution annually | Distribution platform(s) | Number of districts to be treated (as of 08/14) | Total # of eligible people targeted (as of 08/14) |
|---|---|---|---|---|---|
| LF | Entire population ≥5 years of age | 1 | Community-based distribution (door to door and central site) | 21 | 3,943,096 |
| | Entire population ≥5 years of age | 2 | Community-based distribution (door to door and central site) | 4[a] | 636,439 |
| OV | Entire population ≥5 years of age | 2 | Community-based through CDTI | 4 | 142,324 |
| SCH | Children between 5-14 years | 1 | Distribution by health agents | 9 | 726,263 |
| | Children between 5-14 years and high-risk adults | 1 | Distribution by health agents | 10 | 2,589,390 |
| | Children between 5-14 years and high-risk adults | 2 | Distribution by health agents | 7 | 1,717,721 |
| STH | Children between 5-14 years and entire population ≥5 years of age | 1 | Community-based distribution (door to door and central site) and health agents | 33 | 3,278,059 |
| | Children between 5-14 years and entire population ≥5 years of age | 2 | Community-based distribution (door to door and central site) | 4[b] | 256,724 |
| Trachoma | Entire population | 1 | Distribution by health agents | 5[c] | 1,968,208 |

Notes:

[a] These include 4 HDs in Sud-Ouest. In 4 HDs in Sud-Ouest region, the first round of MDA will be funded by END in Africa and the 2nd by CNTD-L.

[b] These will be treated through biannual LF MDA. 4 HDs in the Sud-Ouest region will receive 1 treatment with END in Africa support and 1 treatment with CNTD-L funding.

[c] 5 HDs require district level treatment. Sub-district level surveys will be implemented in 4 HDs with baseline TF prevalence of 5-9.9%. The NTDP expects that sub-district level treatment will be required in 2 of the 4 HDs and therefore expects to need to conduct MDA for trachoma in 7 HDs in FY2015. The NTDP has also made the necessary request for drugs for MDA in these 2 HDs additional HDs throughITI.

**Planned collaboration with partners also supporting MDA activities to ensure complementary coverage, and avoid duplication**

The NTDP will also collaborate with the following agencies that support NTD MDA activities in Burkina Faso:

- **Government of Burkina Faso:** Provides support for LF MDA implementation (supervision, communications activities and drug supplies) and trachoma MDA (purchase of 1% tetracycline ointment).
- **Sightsavers:** Provides financial and technical support for 2 rounds of CDTI to eliminate OV in the Cascades region. For FY2015, 41,816 people are targeted for treatment in the Banfora and Mangodara districts.
- **Canadian Department of Foreign Affairs, Trade and Development (DFATD) via HKI:** In FY2015, financial and technical support will be provided for integrated de-worming and Vitamin A supplementation among children 12-59 months in the Sahel and Est regions.
- **CNTD-L:** In FY2015, financial and technical support provided to conduct the LF MDA will involve the following health regions:
    - Centre-Sud MDA (4 HDs); 643,767 people targeted.
    - Centre-Est (Zabré HD); 117,262 people targeted.
    - 2nd round MDA, Sud-Ouest (4 HDs); 636,439 people targeted.

**The CDD drug delivery platform in Burkina Faso**
The drug distribution strategies for the target populations are as follows:

**Distribution of IVM + ALB:** Community-based distribution is conducted annually, using community volunteers (community health workers or other community resource people). Two distributors are used at each distribution site for a period of at least 6 days, which may be extended if the targets are not reached. Tablets are administered to the population door-to-door in villages (field to field in farming hamlets), and in health centers, barracks, and schools. Treatments for populations at gold-mining sites or other gathering sites will be provided to improve treatment coverage. Health agents will carry out the distributions to increase drug acceptance among urban populations. This significantly reduces the number of cases of individuals who may refuse/be reluctant to take drugs and the need to extend the MDA campaigns.

In 4 HDs in the Sud-Ouest region, where distribution of IVM and ALB for LF and OV will be conducted twice a year, the CDTI platform is used. Each CDD has a treatment register that lists individuals' identity by household.

**Distribution of PZQ:** Health workers distribute these tablets door-to-door, field-to-field or within schools at each site, village or sector. The decision to use health workers for SCH MDA was taken after many adverse side effects were reported at the start of the SCH program and health workers were assigned to distribute the PZQ.

**Distribution of azithromycin + 1% tetracycline eye ointment:** Health workers distribute these medicines at each site, village or sector. These health workers/distributors generally do not live at the sites and are always accompanied by community volunteers or community health workers, who do live in the villages or sites targeted for treatment. The latter are considered guides and organizers and help to reach the greatest number of the population targeted for treatment.

**Distribution of IVM:** Distribution of IVM alone by CDTI for OV is conducted twice yearly (May and November) in 2 HDs in Cascades. Distribution is conducted door-to-door in each of the endemic villages/hamlets. Each CDD has an OV treatment register that lists individuals' identity by household. The CDTI in the Cascades region will be conducted with financial support from Sightsavers. Community

self-monitoring (CSM) will be used in FY2015 to improve treatment coverage and will allow the communities concerned to take responsibility for treatment.

**Actions to be taken to mobilize communities through distribution of IEC materials in support of MDA**
Presently, there are no gaps in terms of programmatic support of MDA in Burkina Faso. To achieve the program's treatment coverage objectives, awareness-raising activities will be conducted to encourage compliance with the MDA, which will involve organizing field visits by health authorities to mobilize the population as part of the planned launch of MDA campaign. The NTDP will organize an information day with opinion leaders in each HD. In addition, radio spots and broadcasts on MDA in French and the local languages will be produced and broadcast throughout the campaigns. Lastly, films will be screened in the areas that registered low coverage during previous MDAs and messages will be disseminated via mobile telephone operators with financial support from the Burkina government.

The activities chosen break down as follows:

**Central level**

- Working with mobile telephone operators to disseminate pro-MDA campaign messages to mobilize the community.
- Reproduce 13,100 sets of IEC materials that have been developed and used in previous MDA campaigns (2,000 brochures for LF; 4,100 posters for LF; 2,000 posters for OV; 3,500 posters for SCH and STH; and 1,500 posters for trachoma).
- Organize field visits by health authorities during launch of the MDA campaigns, which will serve as a springboard for social mobilization activities.
- Produce 4 radio and television spots on the benefits of taking drugs correctly and regularly for LF, OV, SCH, STH, and trachoma in 4 languages (French, Mooré, Dioula and Fulfuldé).
- Broadcast the radio and television spots mentioned above 12 times in French, Mooré, Dioula and Fulfulde.

**Regional level**

- Produce radio spots in 4 local languages (to be determined by each region).
- Produce a broadcast in French for each MDA.

**District level**

- Organize an information day for each MDA targeting administrative, political, traditional and religious leaders at the HD level.
- Broadcast the radio program in French produced by the region one time per MDA.
- Broadcast the radio spots produced by the region during each MDA.
- Produce a broadcast in 2 local languages during each MDA.

**Community level**

In each community, mobilize a public crier responsible for informing the population about the upcoming MDA to encourage participation and ensure high coverage. After each MDA campaign, make-up sessions will be held systematically to treat individuals who were absent during previous visits by community distributors.

**MDA Challenges**

The FY2014 MDA campaigns to combat SCH, trachoma and OV have already been conducted. Based on the provisionally reported results available, epidemiological and program coverage rates are at or above expected levels in all HDs. The LF MDA has not yet been conducted.

Although the HDs show good epidemiological and programmatic coverage, disparities often exist at the village level. This situation is explained, in part, by population movements towards areas that attract populations away from their home villages (for example, gold sites and farming hamlets) and population overestimates in certain areas. In order to improve coverage in these areas, the community distributors will be specifically told to distribute in areas with migrant workers, and to ensure that they enter any camps, villages, workplaces, where these migrants may be found. Those conducting trainings will also be told to emphasize this point during the training sessions.

The FY2014 MDA implementation timeline extends through September (for the last campaign). The final results for the campaigns already conducted are not yet available. The table below thus cannot be completed yet.

**Table 4: Explanation of low USAID-supported program and epidemiological coverage**

*Epidemiological coverage targets are defined below.*

*Programmatic coverage targets are >=80% eligible population*

| NTD | Total number of districts treated in FY14 | Epidemiological coverage targets | Number of districts that did not meet coverage targets in FY14[b] | Reason(s) for poor district performance | Proposed remediation actions |
|---|---|---|---|---|---|
| LF[a] | - | >=65% epi coverage | Epi: | | |
| | | | Program: | | |
| OV | 6 | >=65% epi coverage | Epi: | | |
| | | | Program: | | |
| SCH | 44 | >=75% epi coverage of SAC | Epi: | | |
| | | | Program: | | |
| STH | 55 | >=75% epi coverage of SAC | Epi: | | |
| | | | Program: | | |
| Trachoma | 5 | >=80% epi coverage | Epi: | | |
| | | | Program: | | |

Notes:

[a] LF MDA planned for September 2014.

[b] MDA for OV, SCH, STH (in PZQ + ALB districts), and trachoma has already occurred, coverage data are not yet available.

**Drug and Commodity Supply Management and Procurement**

The logistics office of the NTDP coordination, with technical support from partners, handles the supply, reception, storage and preparation of NTD drug orders. Orders are generally sent to donors based on annual request forms prepared 6 to 8 months before delivery. The projections and logistical quantifications are based on WHO protocols and the target populations defined by each NTDP unit. The national government's budget covers the administrative, customs and transit formalities. The NTDP coordination is responsible for receiving the drugs when they arrive at the ports and arrange for the received drugs to be stored in the warehouse of the disease control directorate (DCD), the directorate within the MOH that oversees the NTDP.

The shipping, transport and delivery of NTD drugs from national level to the lower levels follow these steps:

1. Post-MDA drug stock is reported from the lower levels to the national level and considered when drug supplies are sent to the lower levels.
2. Drug distribution schedules are drawn up before the NTD coordination sends supplies.
3. The NTDP coordination sends supplies to the regions.
4. RHD pharmacies supply the HDs with drug.
5. HDs' pharmacies supply the health centers with drug.
6. Community distributors receive drug needed to treat their communities.

Expired products are managed in accordance with the procedures in the national guidelines for managing expired and unusable products. A committee has been created at each health system level (HD, regions and central level) to validate and initiate the destruction process. During the MDAs, strategies have been adopted to minimize the amount of unusable inventories, such as avoiding opening several bottles at once; ensuring secure drug transport; and allocating the drugs based on the targets.

The program coordination works to minimize harmful environmental impacts associated with MDAs. Waste generated by MDAs are thus managed in accordance with guidelines for managing biomedical waste in medical facilities.

Although the logistics management process is under control, significant problems persist:

- The NTDP coordination has had challenges in recent years with transportation of logistics (specifically with availability of supply trucks). The following steps have been taken to address this: trucks are rented as needed for the central level to supply logistics to the intermediate levels and outlying areas; and necessary resources (fuel, handling and mission costs, road taxes and recalled inventory expenses) are allocated to the HDs and RHDs.
- The central storehouse has limited capacity. This warehouse stores all the drugs used by many of the DHD's departments and programs and usually there is no space for storing NTD drugs. To address this storage shortage, the cost of storing NTD drugs in rented warehouses at the central level will be covered for one month, at a rate of one week/drug before they are transported to lower health levels.
- Inadequate post-MDA management of drug inventory: evaluations of post-MDA drug management will be included in the weekly meetings held in each HD to validate the data regarding the implementation of the MDAs. In addition, TA was received from John Snow Incorporated (JSI) in

FY2014 to train health workers on SCM, and the registers used to keep track of the drug were also revised.

**Table 5: END in Africa Drug and Commodity Procurement (USAID-specific)**

| Drug/commodity | USAID support mechanism (e.g., ENVISION, SCORE, END) | Quantity (tablets/tubes) to be procured | Date of application (MM/YR) | Expected delivery date of drugs (MM/YR) |
|---|---|---|---|---|
| **PZQ** | FHI 360 | 20,753,567 | 02/2014 | 12/2014 |
| **ICT* CARDS** | HKI | 16,000 | 06/2014 | 01/2015 |

*ICT = Immunochromatographic tests

**Monitoring and management of Adverse Events (AEs) and Serious Adverse Events (SAEs)**
The Directorate General of Pharmacies, Medicines and Laboratories (DGPML) houses a pharmaco-vigilance department which includes a committee responsible for investigating SAEs associated with health products and works closely with the NTDP coordination on all SAEs resulting from an NTD MDA. Information relating to AEs is collected, analyzed and disseminated systematically during the campaign. The NTDP has made standard forms for reporting SAEs available to all HDs. During the training sessions held prior to the MDA campaigns, supervisors and distributors are taught or reminded of the process of notification and management of SAEs.

Information about the possible occurrence of SAEs and their management is included in information messages disseminated before, during and after the campaigns. In addition, an information meeting to raise awareness among media representatives will be scheduled before MDA campaigns to ensure that the populations receive correct information on AEs and SAEs to reduce the spread of rumors.

All SAE cases are referred to Medical Centers with Surgical Wings (MCSW), Regional Hospital Centers (RHC) and University Hospitals Centers (UHC) by head nurses for treatment by a physician; this treatment is free of charge to the patient, with costs covered by the Burkinabe government. AE notification forms are completed and sent to higher levels within prescribed timelines. FHI360 and the USAID NTDP will be notified immediately of SAEs using the mechanisms developed as part of the health system pyramid: CHSP investigates and notifies the district → The district investigates, treats and notifies the RHD →RHD investigates and notifies the central level → The central level investigates and confirms the case to the authorities →The technical partners and drug companies are notified and the report is transmitted to them. Community distributors are also asked to keep track of all AEs and SAEs among those treated during MDA.

**Supervision**
Supervision is a necessary part of all MDA campaigns to ensure good quality implementation. For each distribution campaign, each beneficiary structure (central level, RHD, HDs and CHSP) will receive funding for supervision in the form of per diem and fuel in accordance with the budget line in the FOG grant. Vehicles will be provided by the central level as needed. In accordance with the MDA implementation protocols, supervision will be conducted on a cascade basis following the structure of the MDA training.

In addition to financial support, partners (HKI, Fondation pour le Development Communautaire (FDC), and Handicap International (HI)) will assist in monitoring performance of drug distribution at all levels.

The teams will gather information, referring to the activity implementation guides and complying with the national MDA implementation guidelines. These activities will help to ensure the quality of campaign implementation and will be carried out in collaboration with members of the district health management teams and the RHDs. Review meetings to assess implementation will provide an opportunity to discuss performance achievements and shortcomings.

Additional supervisory visits are planned in FY2015 in light of the problems encountered during supervision by various levels of the health care system in the past. The number of supervisors and resources allocated for fuel have been increased after the FY2014 request to improve on the quality of supervision conducted at all levels. In addition, to address the issue of limited resources, TA will also be sought by the NTDP in FY2015 to improve planning and resource management relating to MDA implementation.

In accordance with HKI's internal provisions, a request to conduct an activity and terms of reference for every activity to be implemented must be submitted and validated, based on WHO and national guidelines, before funds are released. Financial and technical support to carry out supervisions, post-MDA surveillance, and informal surveys of village beneficiaries enable the NTDP to ensure that the protocols for implementation of MDA are being followed. Besides these aspects, MDA impact assessment are regularly conducted according to WHO guidelines and their results show whether the MDAs have been effective.

The following activities are planned to help identify and address any problems and bottlenecks that arise during the course of MDAs:

- Independent monitoring of MDAs will enable objective determination of how the MDAs are being carried out and enable immediate decision-making when bottlenecks are detected;

- Supervision will help to assess the actors' performance in conducting MDAs;

- Data collection during implementation will help ensure that the MDAs proceed properly;

- Debriefing meetings among supervisors during the campaign will provide an opportunity to decide on corrective measures.

The following actions are planned to ensure that data are collected and recorded based on pre-established protocols and procedures:

- National guidelines on data management will be provided to all levels;
- Data collection tools will be provided and used taking national procedures and WHO protocols into account;
- Use of the data collection tools will be covered in the training sessions held for all actors (region, HDs, health centers);
- The central level will provide support to the training sessions so that the national guidelines are emphasized;
- Supervisory visits to all operational levels (regions, HDs and health centers) will enable the supervisors to assess and ensure good data quality from data collection to analysis; the increased number of supervisors in FY2015 should reduce the overall workload on each supervisor, enabling him/her to have enough time to provide a thorough supportive supervision.

**Short-term Technical Assistance**

The NTDP coordination is requesting the following specialized TA from NTD partners or the USAID NTDP:

- An expert review and update of the LF elimination strategy in Burkina Faso. The expert/s will also need to advice the NTDP on strategic changes that will be needed based on findings of the study planned for FY2014 to determine causes of the persistence of LF microfilaremia prevalence ≥1% after over 10 years of MDA.
- Support for data quality assessment (DQA). The DQA methodology is new and the NTDP will need training and support to conduct DQA.
- Training of members of the NTDP coordination and HKI NTD team on planning and resource management and on post-MDA surveillance for trachoma and LF. This training is very important because of resource constraint and also because more districts are stopping MDAs for the 2 NTDs and moving to the post-MDA phase.
- Capacity building on financial planning and resource mobilization to be able to address financial gaps detected in the execution of the NTD program. The NTDP wishes to improve capacity of its members on raising funds locally for sustainability of the NTDP.
- Support on SCM and SOPs for NTDs. The NTDP needs training to improve SCM and SOPs for NTDs at all levels.
- Training for NTDP members and HKI on the use of the WHO joint reporting form and joint drug request form.

Table 6 below provides details of the TA requests being made by the NTDP coordination in FY2015.

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

| Task-TA needed | Why needed | Technical skill required | Number of Days required and anticipated/ quarter |
|---|---|---|---|
| An expert review and update of the LF elimination strategy in Burkina Faso | LF elimination strategy has not been reviewed since 2001, when the LF elimination program was created. The expert/s will also need to advice on strategic changes based on findings of the planned study to determine causes of the persistent LF microfilaremia prevalence ≥1%. | Expertise on LF elimination efforts | 4 days ( Second quarter FY2015) |
| Support for data quality assessment (DQA) | To ensure the quality of data reporting | Expertise on conducting DQA | 10 days in January 2015 |
| Training of members of the NTDP coordination and HKI NTD team planning and resource management and on post-MDA surveillance for trachoma and LF | To build NTDP and HKI coordination and M&E capacity | Expertise on implementation of the NTD program and M&E for NTDs | 7 days in November 2014 |

| | | | |
|---|---|---|---|
| Capacity building on financial planning and resource mobilization to be able to address financial gaps detected in the execution of the NTD program | To increase financial planning and advocacy skills for resource mobilization to improve sustainability of the NTDP | Expertise on financial planning and resource mobilization | 7 days (first quarter of FY2015) |
| Support on SCM and SOPs for NTDs | To improve capacity of NTDP staff and other actors involved in SCM for NTDs | Expertise on SCM | 7 days (first quarter 2015) |
| Training of NTDP members and HKI NTD staff on the use of the WHO joint reporting and joint drug request forms | To improve the skill of the NTDP on the use of the 2 forms for reporting and requesting drugs through WHO | Expertise on the 2 WHO forms | 7 days (timeframe to be determined later) |
| Train members of the NTD coordination and HKI partners on the usage of the NTD database developed by RTI | Capacity-building for program management teams to be able to use this database to increase efficiency in NTD program reporting | ENVISION and WHO experts | 7 business days |

**M&E**

**National database roll-out**

The USAID/ENVISION project managed by RTI has developed a new database in collaboration with WHO has developed a new database for managing NTD data generated within countries supported by USAID projects including the END in Africa project. When it is available, the NTDP will require capacity-building through a TA to be able to use this new M&E tool.

**Changes in M&E strategy since the previous work plan**

Trachoma impact assessments at the sub-district level are an innovation for the NTDP and a related protocol must be developed according to WHO guidelines. The GET 2020 Alliance and the TEC have recommended that Burkina Faso conducts surveys at the sub-district level in HDs where baseline TF was 5-9.9% among children 1-9 years old. In FY2015, the NTDP will begin these surveys in the HDs of Barsalogo, Kaya, Fada and Gayeri, which had baseline prevalence close to 10% (9.75%, 9.43%, 7.55%, and 7.50%, respectively). . In 2015, sub-district level MDA is expected and has been planned for Barsalogo and Kaya, as the NTDP believes that some sub-districts would have TF prevalence among children 1-9 years old ≥10%. MDA has not been planned for the other 2 HDs (Fada and Gayeri) and a surveillance plan will be developed and put into place as required.

For LF, TAS I and TAS II will be conducted in 13 HDs, and passive surveillance activities will also be implemented for the first time in all 13 HDs with support from the Government of Burkina Faso.

**Assessment of treatment coverage for OV**

Coverage surveys, as a component of CDTI, will be conducted in the HDs of the Cascades region (Banfora and Mangodara) with Sightsavers' funding and the Sud-Ouest region (Batié, Dano, Diébougou and Gaoua HDs) with financial support from the End in Africa project. CDTI treatment coverage (both epidemiologic and programmatic) is calculated based on data collected from treatment registers.

Epidemiological assessments conducted in areas with high treatment coverage have shown high prevalence rates indicating that treatment coverage rates may not have been as high as reported and may be one of the reasons for the high prevalence, prompting a decision, in accordance with WHO and APOC guidelines, to conduct coverage surveys to determine the true coverage. The results of these surveys will be used to monitor the implementation quality of CDTI and improve its implementation based on survey results.

**Community self-monitoring**

CSM has been a critical component of community participation since the OV program began implementing CDTI activities and will be implemented in all endemic villages in the Cascades and the Sud-Ouest regions. This activity helps ensure coverage and sustainability of the program. In addition, it allows all actors involved in CDTI implementation to hold discussions with the populations of the endemic villages about bottlenecks that could block progress in eliminating OV and also provides an opportunity to find ways of improving future CDTI campaigns. The End in Africa project will fund CSM activities in the Sud-Ouest while Sightsavers will fund CSM activities in the Cascades regions.

**Independent monitoring of treatment coverage**

Independent monitoring of MDA will be carried out in FY2015 in 4 HDs. Independent monitoring will be used to assess the actors' and beneficiaries' knowledge on MDAs, assess the relationship between observed and reported coverage, estimate the extent of side effects, and assess the general organization of campaigns. The independent monitoring will be carried during MDA campaigns. The results will help to improve the quality of the MDA campaigns by proposing corrective measures (awareness-raising, team organization, supervision and the identification and management of side effects). These assessments will be conducted by HKI with support from other donors.

**Table 7: Planned Disease specific Assessments (DSAs) by Disease**

| DSA Type | # DSA Targeted with USAID Support (as of 08/14) | Names of districts where DSA to take place |
|---|---|---|
| LF baseline or midterm sentinel/spot check site | 0 | Control sites to be determined |
| LF Pre-TAS sentinel/spot check site | 11 | Boromo, Dédougou, Bittou, Garango, Zabré, Léo, Sapouy, Batié, Dano, Diébougou, Gaoua |
| LF TAS: Stop MDA | 4[a] | Kombissiri, Manga, Po, Saponé |
| LF TAS: Post-MDA Surveillance (I or II) | 13[b] | Boussé, Ziniaré, Zorgho, Dori, Djibo, Gorom-Gorom, Do, Dandé, Houndé, Baskuy, Dafra, Karangasso Vigué, Lena |
| OV epidemiological assessment | 0 | |
| Schisto sentinel/spot check site/evaluation | 0 | |
| STH sentinel/spot check site/evaluation | 0 | |
| Trachoma impact survey | 4 | Dafra, Dandé, Karangasso Vigué, Signonghin |
| Trachoma Post-MDA Surveillance | 0 | |
| Other (Trachoma sub-district-level surveys) | 4 | Gayéri, Fada, Kaya, Barsalogho, |

Notes:
[a] END in Africa funds will be used to purchase the ICT cards, but the Government of Burkina Faso will cover the costs of the surveys themselves.
[b] END in Africa funds will support 10 of the surveys and the Government of Burkina Faso will cover the cost for the other 3 HDs; END in Africa funds will be used to purchase ICT cards for all 13 HDs.

**LF Pre-TAS at sentinel/spot check sites**

The NTDP will conduct pre-TAS for 11 HDs in 15 sentinel/spot check sites in FY2015 in accordance with WHO recommendations for LF elimination. Among the 15 sentinel/spot check sites, pre-TAS will be conducted in 10 with financial support from the End in Africa project, and pre-TAS in the other 5 sentinel/spot check sites will be funded by CNTD-L. The sites and HDs that will be supported by END in Africa include: Boucle du Mouhoun (Boromo HD: 1 site; Dédougou HD: 2 sites); Centre-Est (Bittou HD: 1 site; Garango HD: 1 site; Zabré HD: 1 site); Centre-Ouest (Léo HD: 2 sites; Sapouy HD: 2 sites). The results of the pre-TAS will help to determine whether TAS can be conducted in these HDs.

**LF TAS**

In connection with the pre-TAS survey conducted in FY2014, a TAS is scheduled for FY2015 in 4 HDs in the Centre-Sud region (Kombissiri, Manga, Pô and Saponé HDs) with funding from the national government while ICT cards will be purchased with USAID/END in Africa funds.

**Trachoma Impact surveys**

In HDs that have implemented at least 3 consecutive rounds of MDA, impact assessments are required to evaluate the epidemiological situation of active trachoma and determine the effectiveness of the MDA. In FY2015, impact surveys will be conducted in 4 HDs across 2 health regions (Signonghin HD in the Centre region and the Dafra, Dandé and Karangasso Vigué HDs in the Hauts Bassins region) that have completed 3 rounds of MDA. The results will help to determine whether to halt or continue MDAs at the district level. The End in Africa project will provide financial support for all these assessments.

**Trachoma sub-district level surveys**

The 2005-2010 baseline surveys for trachoma showed that 15 HDs had TF prevalence between 5% and 9.9% among children 1-9 years of age. Since the mapping, the SAFE strategy has not been implemented in these districts. The NTD program proposes to conduct sub-district level surveys in 4 of these HDs in FY2015 to determine whether sub-district level MDA is required. These include 4 HDs of Barsalogo, Kaya, Fada and Gayeri, which had baseline prevalence of 9.75%, 9.43%, 7.55%, and 7.50%, respectively. Current WHO guidelines indicate that those HD with baseline TF prevalence between 5-9% conduct surveys at the sub-district level to determine whether MDA is necessary in any sub-districts. .

**Use of DSA results to address key MOH needs**

- The results of trachoma impact assessment at the sub-district level will be shared with partners (including WHO, GET2020 Alliance, the International trachoma Initiative (ITI), TEC, HKI, USAID, FHI360 and Sightsavers) to support decision-making on the elimination objectives and will be used to decide whether treatment should be continued or stopped.
- The final implementation reports of the LF pre-TAS, TAS and post-MDA surveillance will also be distributed to international NTD partners (WHO, HKI, USAID and FHI360) to support decision-making on achieving the elimination objectives.
- All reports of DSAs for trachoma and LF will be presented to the newly formed WHO NTD Regional Peer Review Group (NTD RPRG) for review and guidance on the way forward towards the elimination of the 2 PC NTDs.

**Strategies for addressing DSAs that did not achieve critical cut-off, and how lessons learned will be applied to future DSAs**

The results of DSAs conducted in FY2014 are not yet available but once available, will be used to make programmatic decisions such as whether MDA can be stopped or continued in the areas surveyed. In addition, lessons learned from the FY2014 DSAs will be used in a similar manner as those observed during the FY2013 DSAs. In FY2013, a number of planning problems were detected, such as delays in the availability of final survey data, the non-validation of certain protocols, and a lack of a protocol for sub-district-level surveys for trachoma. HKI is supporting the NTDP to develop survey protocols before DSAs are conducted and will work with the NTDP to ensure that DSA results are made available as soon as possible following the assessments.

**LF post-MDA surveillance survey (TAS I and TAS II)**

In accordance with WHO guidelines, post-MDA surveys are required in HDs where treatment was stopped at least two years earlier to determine whether there is any evidence of ongoing transmission. These surveys are required as part of the elimination certification process. TAS I will be conducted in 7 HDs of Centre (Baskuy), Plateau-Central (Boussé, Ziniaré and Zorgho) and Sahel (Dori, Djibo and Gorom-Gorom) regions and will be funded by the END in Africa project. TAS II will be conducted in 6 HDs of the Hauts Bassins region (Dafra, Dandé, Do, Houndé, Karangasso Vigué, and Lena). The END in Africa project will fund TAS II in the Do, Dandé and Houndé HDs, and the national government will fund TAS II in Dafra, Karangasso Vigué and Lena HDs, although the all the ICT cards needed for the 6 HDs will be purchased by the END in Africa project.

**LF post-MDA passive surveillance**

Pursuant to WHO recommendations, the post-MDA passive surveillance began with the development of national implementation guidelines for post-MDA passive surveillance in 2013. Thirty-five biomedical technicians (BMT) from all the 13 health regions were trained, a national passive surveillance committee was formed, and laboratories received the required supplies. To implement this passive surveillance in the regions where LF MDA was stopped (Hauts Bassins, Nord, Plateau-Central, Cascades and Sahel), the following activities are planned in FY2015: provision of reagents and laboratory consumables to the health facilities in the regions concerned (to be funded by the government), refresher training of the BMTs, supervision, quality control and consultation forums (all with financial support from the END in Africa project).

**Data quality assessments (DQA)**

The NTDP plans to conduct DQA in the near future but lacks the necessary skills to implement this activity. The NTDP will therefore need TA on DQAs in FY2015. Staff from the MOH Center for Health Information and Epidemiological Surveillance (CHIES), MOH pharmaceutical assistants, pharmacists and members of the NTDP coordination and HKI NTD staff are expected to participate in the training that will be provided. Assessment of the quality and consistency of data collected during the MDA campaigns and other M&E activities is necessary for the NTDP to make better decisions while progressing towards its goals for control and elimination of the PC NTDs.

**Specific M&E challenges anticipated in FY2015 and how they will be addressed**

The main challenges expected by the NTDP in carrying out M&E activities including DSAs include the following:

1. Conducting M&E and other program activities with no breaks in between delays completion and submission of the survey and/or assessment reports, which, in turn, creates delays in making periodic updates to the national database. To address this more staff have been employed recently to support M&E activities of the NTDP.

2. The delay in receiving ICT cards to carry out LF TAS and post-MDA surveillance assessments has interrupted the program's activity agenda. HKI will ensure that orders for ICT cards are made to ALERE at least 4 months before the surveys are to be conducted.

3. The need to conduct DSAs for PC NTDs is increasing and many health regions have to be surveyed each year. The few research technicians available at central level are now overwhelmed by the amount of work they have to do. The limited involvement of staff at lower levels in the implementation of DSAs has been noted on several occasions. This problem will be addressed by training and involving technicians from the regions and districts to (1) increase the number of technicians available for DSAs, and (2) to reduce the work days and travel time of the technicians at central level. Provision has been made in the FY2015 budget for technicians from regions and districts to be identified, trained and involved in future DSAs.

4. New staff were recently appointed within the NTDP coordination and the HKI NTD team as part of the effort to improve on the quality of M&E activities. The NTDP and HKI will therefore need TA to build capacity on M&E. The new M&E personnel will need trainings on general NTD coordination, the WHO joint reporting and joint drug request forms, post-MDA surveillance for trachoma and LF.

**Planned FOGs to local organizations and/or governments**

**Table 8: Planned FOG recipients**

| FOG recipient (split by type of organization) | Number of FOGs | Activities |
|---|---|---|
| General Health Directorate | 1 | • Provide an orientation session for trainers on implementing MDA campaigns<br>• Support training sessions for teams from the regions and HDs on implementing MDA campaigns<br>• Ensure that RHDs receive drug supplies for MDAs<br>• Supervise regional and health district teams' implementation of all FY2015 mass treatment campaigns<br>• Conduct data collection at sentinel sites (LF + STH)<br>• Conduct TAS<br>• Conduct trachoma treatment impact studies<br>• Conduct trachoma prevalence surveys in health sub-districts<br>• Carry out post-MDA surveillance activities after LF and trachoma MDAs are stopped<br>• Conduct CDTI, epidemiological evaluation, treatment coverage |

| | | |
|---|---|---|
| | | surveys and CSM<br>• Carry out communications activities (IEC/BCC) to encourage strong community participation in NTD elimination activities |
| Health regions | 11 | • Provide training sessions for regional, HDs and health center teams on implementing MDA campaigns<br>• Supervise HDs, CHSPs and distributor teams' implementation of all FY2015 mass treatment campaigns<br>• Ensure that HDs and CHSP receive drug supplies for MDAs<br>• Carry out communications activities (IEC/BCC) to encourage strong community participation in NTD elimination activities |

**Summary of NTD partners working in country**

**Table 9: NTD partners working in country and summarized activities**

| Partner | Location | Activities | Is USAID providing financial support to this partner? |
|---|---|---|---|
| West African Water, Sanitation and Hygiene project (WA WASH) | Burkina Faso health regions | Promote low-cost water supply techniques<br>Promote latrine construction<br>Build private sector capacity to produce and promote water pumps<br>Develop decision makers' capacity in the area of gender promotion | Yes |
| Water Aid | Boucle du Mouhoun, Centre, Centre-Est, Centre-Ouest, Centre-Nord, l'Est, Sud-Ouest, Sahel. | Implement sustainable drinking water supply systems<br>Build and promote use of latrines. | Yes |
| Handicap International | 13 Burkina Faso health regions | Technical support to supervise MDA campaigns | No |
| FDC | 13 Burkina Faso health regions | Technical support to supervise MDA campaigns | No |
| CNTD - L | Sud-Ouest, Centre-Sud, Zabré health district | Technical and financial support for M&E activities<br>Technical and financial support for IEC/BCC activities on NTDs | No |

| | | | |
|---|---|---|---|
| | | Technical and financial support to implement MDA components in several districts | |
| HKI | Central Level, 13 Burkina Faso health regions | Technical and financial support to implement MDA components | Yes |
| | | Technical and financial support for M&E activities | |
| | | Support for coordination and provision of technical assistance for capacity development | |
| | | Technical and financial support for specific studies | |
| | | Technical and financial support for IEC/BCC activities on NTDs | |
| | Koudougou and Sapouy districts | Support for trichiasis surgery in HDs | No |
| | DFATD | Financial support for de-worming children ages 12-59 months during Vitamin A supplementation day | No |
| SIGHTSAVERS | Cascades | Technical and financial support to implement CDTI components in the Cascades region | No |
| | | Technical and financial support for CDTI M&E activities | |
| | | Support for coordination operations | |
| | | Technical and financial support for IEC/BCC activities on onchocerciasis and trachoma | |
| | | Support for trichiasis surgery | |

**Looking Ahead**

**MDA**

If additional funds are made available, the NTDP wishes to implement biannual treatment for LF in the districts of Est (6 HD) and Centre-Est regions (7 HD), due to the persistent high microfilaremia prevalence. This is now postponed until after the proposed studies to determine reasons for this persistent high LF prevalence and the proposed LF expert review and recommendations.

Additional MDA may be required for trachoma in HDs with baseline prevalence of 5-9.9% that will undergo sub-district level surveys as per recommendations from the GET2020 Alliance and the TEC. While the number of sub-districts cannot be determined until after the surveys, the NTDP believes that 2 HDs will require subdistrict MDA in FY2015.

Finally, as noted in the MDA section, not all HDs are treated every year for STH, since 33 HDs have now stopped MDA for LF, and not all HDs receive SCH MDA every year. If additional funding were made available, MDA with ALB only would be provided in the HDs that do not have LF MDA or SCH MDA..

**Complementary M&E activities**

The OV epidemiological situation must be updated so that residual pockets are not overlooked if elimination is to be reached. The results of the epidemiological evaluations conducted in 2010 indicate a troubling situation in some of the Comoé basin villages. Twenty-two of the 28 villages evaluated had prevalence rates ranging from 0.67% to 70.97%, 13 of which were above the tolerable threshold of 5%. Furthermore, none of the individuals who tested positive – including children under 10 years – had spent long periods outside the area. It is worth noting that these results were obtained after annual LF MDAs were conducted in the area between 2003 and2012. This means that OV is still being transmitted locally in some Comoé basin villages. It should also be noted that the Comoé basin extends from within the Cascades region into Cote d'Ivoire, where treatment for OV was stopped and restarted a few years back due to civil conflict. Based on this background, the NTDP believes that it is essential to conduct epidemiological assessments of the country's other river basins (specifically, the Mouhoun, Nakambé and Nazinon and their tributaries). Such an assessment would make it possible to: (1) specify the prevalence of OV in the basins selected; (2) update Burkina Faso's OV map; and (3) enable the NTDP to better organize efforts to control this disease in the country's interior. It will also be necessary for the NTDP to collaborate with neighboring countries for treatment in border areas.

With WHO/APOC funding, epidemiological assessments have already been conducted in 2014 in the Hauts Bassins (1 health district) and Boucle de Mouhoun (6 health districts) regions. They will continue based on the same funding, in the regional health directorates of the Centre-Sud and Centre-Est. FY15 funding is being sought to conduct an epidemiological assessment in the Est region to assess the Oti Pendjari and Tapoa river basins and their tributaries.

Based on WHO recommendations, entomological assessments for OV should also be conducted in the areas where the infection is already zero or close to zero. Entomological studies will thus be organized in FY2015 in the basins of the Haut Mouhoun, Nizinon, Sissili and Nakambé.

The HDs involved include:

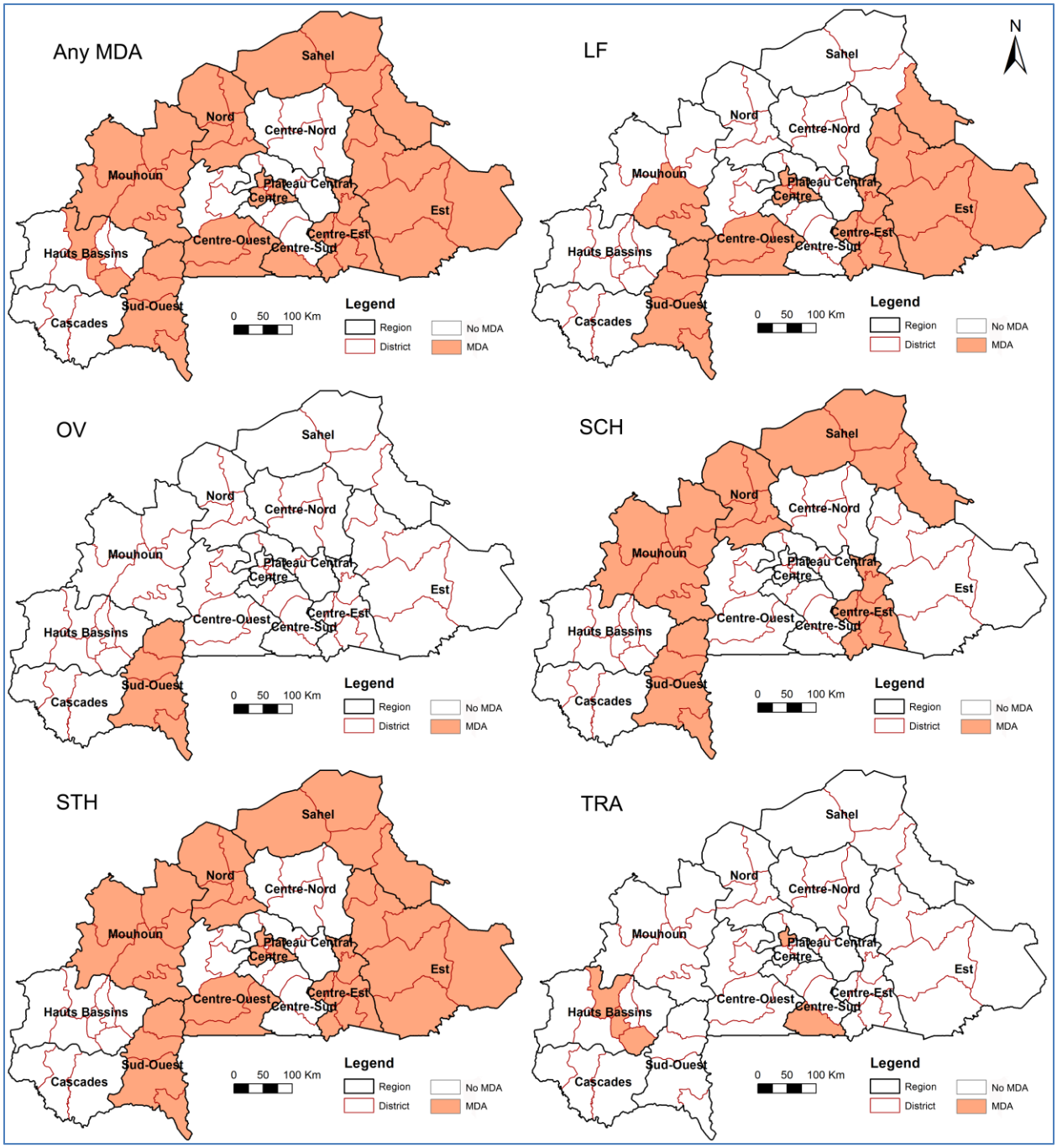
- Boromo, Solenzo, Dédougou, Nouna, Tougan and Toma in the Boucle de Mouhoun region
- Dandé in the Hauts Bassins region
- Po in the Centre-Sud region
- Bittou and Zabré in the Centre-Est region.

**Table 10: Remaining gaps to be addressed**

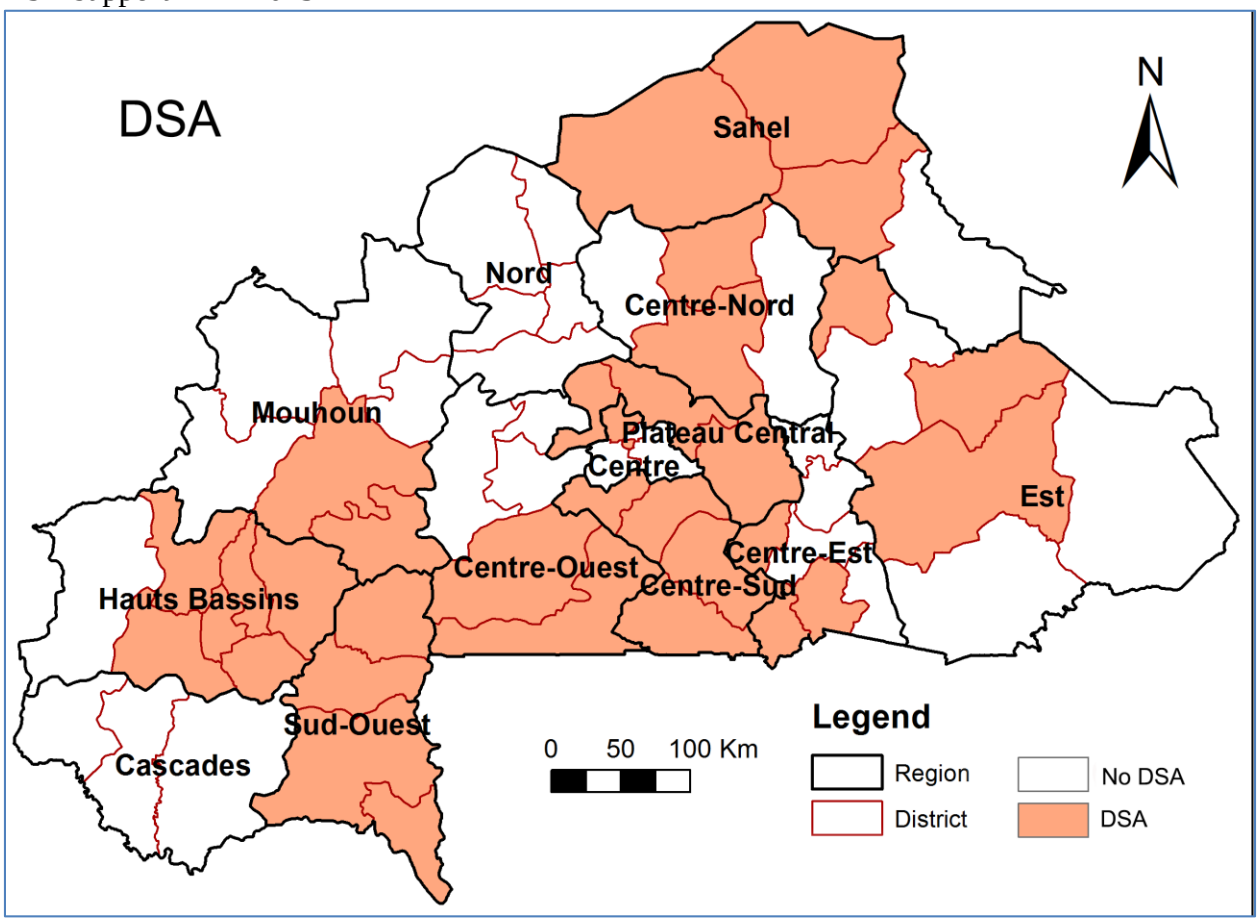
| Identified gap or activity | Would external support be needed –funding or technical (outside of existing partners)? | Estimated time needed to address activity | Estimated cost to carry out activity |
|---|---|---|---|
| Support epidemiological evaluations for OV in the Eastern RHDs | Yes - financial | 2 months | To be determined |
| Support entomological evaluations for OV in the Boucle de Mouhoun, Hauts Bassins, Centre-Sud and Centre-Est regions | Yes - financial | 3 months | To be determined |

**Figure 1: USAID NTD support map of Burkina Faso**

The map below shows the 13 regions of Burkina Faso, which will all be supported for MDA in FY2015 by the USAID NTDP for the control/elimination of the 5 targeted PC NTDs.



DSA support in FY2015




*All 13 regions and all 63 HDs of Burkina Faso are supported for the control/elimination (support for mapping, MDA, DSA and BCC activities) of at least 1 PC NTD.
** Appendix 3 (provided as an attachment) shows details of activities supported in each of the 63 HDs.