Burkina Faso

FY2016

Control of Neglected Tropical Diseases

Annual Work Plan
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Acronyms and Abbreviations

2IE	International Institute of Water and Environnemental Engineering (Institut International d'Ingénierie de l'Eau et de l'Environnement)
APOC	African Programme for Onchocerciasis Control
BCC	Behavioral Change Communications
CDC	U.S. Centers for Disease Control and Prevention
CDTI	Community-Directed Treatment with Ivermectin
CHR	Regional Hospital (Centre Hospitalier Régional)
CISSE	Center for Health Information and Epidemiologic Surveillance (Centre d'Information Sanitaire et de Surveillance Epidémiologique)
CMA	Medical Center with Surgical Wing (Centre Médical avec Antenne Chirurgicale)
CMFL	Community Microfilarial Load
COGES	Management committee (comite de gestion)
CS	Control (Spot-Check) Site
CSM	Community Self-Monitoring
CSPS	Center for Health and Social Promotion (Centre de Santé et de Promotion Sociale)
DfID	Department for International Development
DGS	General Directorate of Health (Direction Generale de la Santé)
DLM	Disease Control Directorate (Direction de la Lutte contre la Maladie)
DQA	Data Quality Assessment
DRS	Regional Health Directorate (Direction Régionale de la Santé)
DS	District Sanitaire (Health District)
DSA	Disease Specific Assessment
ECD	District Management Team (Equipe Cadre du District)
EU	Evaluation Unit
FHI360	Family Health International 360
FOG	Fixed Obligation Grant
FPSU-L	Filarial Programmes Support Unit-Liverpool School of Tropical Medicine
FTS	Filariaisis Test Strip
FY	Fiscal Year
GAELF	Global Alliance for Elimination of Lymphatic Filariasis
GET 2020	Alliance for the Global Elimination of Blinding Trachoma by 2020
HAT	Human African Trypanosomiasis
HI	Handicap International
HKI	Helen Keller International
HD	Health District
ICP	Head Nurse (Infirmier Chef de Poste)
ICP	Integrated Communications Plan
ICT	Immunochromatographic Test
IDB	Integrated Database
IEC	Information, Education, Communication
IMF	International Monetary Fund
ITI	International Trachoma Initiative
JSI	John Snow, Inc.
KAP	Knowledge, Attitude and Practice
LF	Lymphatic Filariasis

LSTM	Liverpool School of Tropical Medicine
MDA	Mass Drug Administration
M&E	Monitoring and Evaluation
MMDP	Morbidity Management and Disability Prevention
NMIR	Noguchi Memorial Institute for Medical Research
MOH	Ministry of Health
NTD	Neglected Tropical Disease
NTDP	Neglected Tropical Diseases Program
Oncho	Onchocerciasis
PC NTDs	NTDs targeted through preventive chemotherapy
PNDS	National Health Development Plan (Plan National de Développement sanitaire)
PNMTN	Programme National de lutte contre les Maladies Tropicales Négligées (National NTD Program)
PSN	National Health Policy (Politique Sanitaire Nationale)
RGPH	General Population and Habitat Census (Recensement General des Populations et de l'Habitat)
RTI	Research Triangle Institute International
SCH	Schistosomiasis
SCI	Schistosomiasis Control Initiative
SOPs	Standard Operating Procedures
SS	Sentinel Site
STH	Soil-Transmitted Helminthes
TAS	Transmission Assessment Survey
TEO	Tetracycline Eye Ointment
TF	Trachomatous Inflammation Follicular
TIPAC	Tool for Integrated Planning and Costing
TT	Trachomatous Trichiasis
TV	Television
UEFL	Lymphatic Filariasis Elimination Unit (Unité d'élimination de la filariose lymphatique)
ULO	Onchocerciasis Control Unit (Unité de lutte contre l'onchocercose)
ULSc/STH	Schistosomiasis/Soil-transmitted Helminths Control Unit (Unité de luttecontre la schistosomiase/Soil transmitted Helminthes)
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

COUNTRY OVERVIEW

General background information on country structure

Burkina Faso is a land-locked country covering 274,200 square kilometers in the heart of West Africa. It shares borders with six countries: Mali to the west and north, Niger to the east, and Benin, Togo, Ghana and Ivory Coast on the south. Burkina Faso has a tropical climate with two main seasons: a long dry season from October to May and a short rainy season from June to September. Three rivers—the Mouhoun, Nazinon and Nakambé—drain the country. Based on the 2006 census population of 14,017,262[1] and an annual growth rate of 3.1%, the 2016 estimated population is 19,034,397.[2] Population density averages approximately 69 inhabitants per square kilometer. A former colony of France, the official language is French, though more than 60 languages are spoken in the country. Predominant languages include, Mòoré, Dioula, Peuhl, Gourmanché, and Bissa. Main ethnic groups include the Mossi, Bobo, Gurunsi, and Fulani.

For administrative purposes, Burkina Faso is divided into 13 regions, 45 provinces, 350 departments, 351 communes (49 urban and 302 rural) and 8,228 villages. The health system is administered by 13 Regional Health Directorates (*Direction Regionale de la Santé*, or DRS), which correspond to the 13 administrative regions. These 13 DRS are divided into and oversee the 70 health districts[3] (*District Sanitaire*, or DS), which oversee district-level health facilities and 1,643 Centers for Health and Social Promotion (*Centre de Santé et de Promotion Sociale*, or CSPS),[4] which are front-line health clinics at the community level.

The Burkina Faso national health policy, or *Politique Sanitaire Nationale* (PSN), is implemented through the national health development plan, or *Plan National de Développement Sanitaire* (PNDS) with a goal to improve the population's health. The current plan covers 2011 through 2020, and includes Neglected Tropical Diseases (NTD) as a national priority. The Burkina Faso Ministry of Health (MOH) implements activities to fight NTDs with funding from several sources. The United States Agency for International Development (USAID) has contributed to the fight against NTDs in Burkina Faso since 2007. The MOH receives USAID funds through the END in Africa project, managed by Family Health International 360 (FHI360), with technical and administrative support from Helen Keller International (HKI) and other partners. The following donors and partners also support PC NTD activities[5] in Burkina Faso:

- **Government of Burkina Faso:** provides support to implement activities to control and combat NTDs (including mass drug administration (MDA) for lymphatic filariasis (LF), LF morbidity management, LF impact assessments, MDA for soil-transmitted helminthes (STH), and supplies of 1% tetracycline eye ointment (TEO) for the trachoma MDA. The government also provides significant logistical (vehicle) support to conduct and supervise the MDAs and impact assessments. It provides support for drug supplies by establishing exemptions from customs formalities and charges for the entry of drugs and other inputs used in NTD control efforts.

[1] 2006 Recensement Général de la Population et de l'Habitat (2006 General Population and Housing Census)
[2] 2011-2020 National Program for Health Development (PNDS)
[3] Burkina Faso recently increased the number of health districts from 63 to 70. The seven new HDs were created by dividing several of the larger health districts, and are in the process of becoming fully functional.
[4] 2014 Statistics directory
[5] Donors and partners that provide support for STH deworming activities through nutrition, child health, and school health projects, rather than NTD programs are not included on this list.

- **Sightsavers:** financial and technical support for efforts to combat trachoma morbidity and implement community-directed treatment with ivermectin (CDTI), cross-border meetings and monitoring-evaluation efforts to eliminate onchocerciasis and trachoma in the Cascades region. A trachomatous trichiasis (TT) surgery support project will be implemented in the Nord region in 2016.

- **Filarial Programmes Support Unit (FPSU) of Liverpool School of Tropical Medicine (LSTM):** financial and technical support for implementation of LF elimination activities: sentinel site (SS)/control site (CS) evaluations, Transmission Assessment Surveys (TAS) surveys, post-MDA monitoring, and MDA support. The Sud-Ouest, Centre-Sud, and Centre-Est (Zabré health district (HD)) regions receive support.

- **FHI 360 via CARE:** support for USAID-funded WASHplus pilot project in Manni HD.

- **International Institute for Water and Environmental Engineering / Institut International d'Ingénierie de l'Eau et de l'Environnement (2iE):** support for Information, Education and Communication (IEC) and research activities in the regions of Centre-Est (Koupéla HD), Nord (Ouahigouya HD) and Hauts-Bassins (Dafra HD) as part of efforts to control and combat schistosomiasis.

- **Health center management committees (COGES):** Health district management committees (or *Comité de Gestion*) manage local monies to support health activities. These committees have occasionally allocated funds to support MDAs, primarily through financial incentive to CDDs. This funding is not accessible in all HDs and difficult to evaluate in terms of monetary value.

- **World Bank/International Monetary Fund (IMF):** The World Bank has committed US$121 million to support sub-regional efforts combat NTDs targeted through preventive chemotherapy (PC NTDs) and seasonal malaria treatment among children ages 3-59 months of age in Mali, Niger, and Burkina Faso. This multi-year funding opportunity prioritizes health districts along the borders of the three countries. In Burkina Faso, proposed activities are MDA and surveillance in 22 districts bordering Niger and Mali. All the activities under this project will be validated prior to the release of funds, which could begin in 2016.

Table 1: NTD partners working in country, donor support and summarized activities

Partner	Locations (Regions/ States)	Activities	Does USAID provide direct financial aid to this partner? *(Do not include FOG recipients)*	Do other donors support these partners/ activities?
FHI360 / CARE	Est: Manni HD	Support for Washplus activities	Yes	None
2IE	Koupéla, Ouahigouya, & Dafra HDs	Support for IEC and research activities as part of efforts to combat schistosomiasis	No	None

Partner	Locations (Regions/ States)	Activities	Does USAID provide direct financial aid to this partner? *(Do not include FOG recipients)*	Do other donors support these partners/ activities?
HKI	13 Burkina Faso health regions	Technical and financial support to implement MDA	Yes	No
		Technical and financial support to conduct monitoring and evaluation (M&E) activities		
		Support to coordinate and provide technical assistance for capacity building		
		Technical and financial support to conduct specific studies		
		Technical and financial support for NTD IEC/behavior change communication (BCC)		
	Centre-Nord	Morbidity Management and Disability Prevention (MMDP) for LF and trachoma		No
	Est: Fada HD	Trachoma activities in context of school health project S,F, and E components of SAFE strategy in schools and surrounding communities	No	Yes (Embassy of Taiwan)
FPSU-LSTM	Sud-Ouest, Centre-Sud regions; Zabré HD	Technical and financial support to operate and conduct M&E activities	No	Yes (DFID)
		Technical and financial support to conduct LF IEC/ BCC activities		
		Technical and financial support to implement MDA		
		Treatment of LF cases		
		Research		
Sightsavers	Cascades	Technical and financial support to implement MDA through the CDTI method	No	Yes (DFID)
		Technical and financial support for cross-border meetings and to conduct M&E activities		
		Financial support for the NTD coordination		
		Technical and financial support for onchocerciasis and trachoma IEC/BCC activities		
		Support for trichiasis surgery		
	Nord	Support for trichiasis surgery		
World Bank / IMF	Nationwide, with priority given to 22 HDs that border Mali or Niger	Technical and financial support to implement MDA	No	None
		Technical and financial support to conduct M&E activities		
		Support to coordinate and provide technical assistance for capacity building		
		Technical and financial support to conduct specific studies		
		Technical and financial support for NTD IEC/BCC activities		
		Support for morbidity management and capacity-building activities		

National NTD Program Overview

The Burkina Faso MOH, through the National NTD Program, or *Programme National de lutte contre les Maladies Tropicales Négligées* (PNMTN), coordinates the integrated control activities for the five NTDs that can be treated with preventive chemotherapy (PC NTDs): lymphatic filariasis (LF), onchocerciasis (oncho), schistosomiasis (SCH), soil-transmitted helminths (STH), and trachoma. Regional Health Directorates oversee and supervise implementation by the health districts (HD). Health districts organize and implement NTD activities at the district, CSPS, and community levels. Both community-based and school-based platforms are used for drug delivery to the eligible population by community health workers (CHW), community drug distributors (CDD), health workers, and teachers. District and regional reference hospitals manage any serious adverse events.

The National Onchocerciasis Program was established in 1991, the National LF Elimination Program in 2001, the National Blindness Prevention Program with trachoma under its mandate in 2002, and the National Schistosomiasis/STH program in 2004. Integration of the disease-specific programs into a unified National NTD Program (the PNMTN) was achieved in 2007. The PNMTN is made up of 10 units, each led by a unit head. The 10 units include six disease program and technical units: trachoma, LF, Oncho, SCH/STH/Guinea Worm, Human African Trypanosomiasis (HAT), and Leprosy/Buruli Ulcer/Leishmaniasis; and four cross-cutting units: logistics, laboratory, communication (IEC/BCC), and planning and monitoring and evaluation. The PNMTN also receives input and advice from the technical and steering committees, which meet two to four times per year. The PNMTN is part of the Disease Control Directorate (*Direction de la Lutte contre la Maladie*, DLM). The DLM, in turn, is part of the General Health Directorate of the MOH.

USAID Support

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

Since 2011, USAID NTD support in Burkina Faso has been provided through the END in Africa Project. Managed by FHI360 with HKI as implementing partner, the Project has enabled the national NTD program to continue, expand, and improve delivery of: MDAs for the five NTDs targeted through PCT, M&E (impact assessments, pre-TAS, TAS, and post-MDA surveillance) to assess progress, and build capacity of actors at all levels through training and technical assistance. Technical assistance (TA) has included the review of the schistosomiasis strategy, review of the LF strategy, an action plan for trachoma elimination, logistical management, and use of the tool for integrated planning and costing (TIPAC). During this time, MDAs for LF have stopped in 33 of 63 HDs endemic at baseline, and MDAs for trachoma have stopped in 25 of 30 HDs endemic at baseline[6]. More than 80 million treatments (80,758,084) were provided during MDAs between 2011 and 2014: LF 29,444,372; schisto 15,139,287; oncho 549,663; STH 24,849,508; and trachoma 10,775,254).

[6] Numbers of health districts cited correspond to the 63 HDs through FY15, rather than the current 70 HDs.

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

Lymphatic Filariasis

The Ministry of Health has set a goal to eliminate LF as a public health problem by 2020 using the following strategies: MDA, treatment of LF complications (hydrocele and lymphedema), advocacy and BCC, vector control, surveillance, and capacity building. LF was found to be endemic in all 63 (now 70) HDs following the completion of mapping in 2002. Full geographic coverage of MDAs to endemic HDs was achieved in 2005. Transmission Assessment Surveys (TAS) have been implemented in a number of districts, with largely successful results: 33 of 63[7] HDs have now stopped annual MDA. Among the 33 districts that have stopped MDA, 22 have also conducted TAS2, and all have shown that transmission has been interrupted. TAS 3 surveys started in 2015. Results from two EU (three HDs) in the Hauts Bassins Region confirmed the halt of transmission in these areas. Four districts in one region conducted pre-TAS, but results showed the districts were not eligible to conduct TAS1. These four districts, all in the Centre Region, have both urban and rural areas. The urban areas are all part of Ouagadougou, the largest city in Burkina Faso. Evaluation showed that only the rural areas required continued MDAs, so MDAs continue in the rural areas of the districts, but not in Ouagadougou.

Persistent pockets of disease—areas where prevalence remains high after more than 10 rounds of MDA—is a current challenge for the program, particularly in the southern part of the country. Twenty three districts in five regions—Est, Centre Est, Centre Sud, Centre Ouest, and Sud Ouest—have conducted between 13 and 18 rounds of treatment, without reaching the criteria to stop MDA. Highly mobile populations—both within the country to clandestine gold mining sites and to find work, and to neighboring Ivory Coast, which has not begun LF MDAs—is another operational challenge being addressed in the push towards LF elimination.

Onchocerciasis

Six HDs in the Cascades and Sud Ouest regions are OV endemic. 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 MDA via the CDTI strategy, BCC, advocacy, epidemiological and entomological surveillance, vector control efforts and capacity building. MDA is currently conducted twice per year in the two districts in the Cascades Region, with Sightsavers supporting both rounds. The four districts in the Sud Ouest region are supported by END in Africa on one round and by FPSU-L for the other. The most recent evaluations showed considerable decreases in Community Microfilarial Load (CMFL) in these HDs. Results from 2010 in the Cascades region show a prevalence of 71% in Banfora HD and 33.9% in Mangodara HD. Results from the four endemic districts in the Sud Ouest region show a prevalence range from 1.9% in Diébougou HD to 9.7% in Batié HD. However, MDA still needs to continue in order to meet the upcoming elimination target of 2025.

Schistosomiasis

SCH is endemic in all 70 HDs. The national objective is to reduce the prevalence of SCH to less than 10% 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 strategies include: MDA, environmental

[7] Numbers of health districts cited correspond to the 63 HDs through FY15, rather than the current 70 HDs.

sanitation, BCC, advocacy, surveillance and capacity building. In 2013, an experts review meeting was held to examine the prevalence data and treatment schedule, and to recommend changes to the treatment scheme in order to assist Burkina Faso meet the objectives above. Based on this review, the treatment strategy was adapted to align with WHO recommendations, and was put into action in 2015. The new treatment scheme is divided by region, with treatments on an annual, biannual or biennial basis, depending on prevalence. (Details provided in the disease workbook).

Soil-Transmitted Helminthes

STH are endemic in all 70 HDs in Burkina Faso. The national objective is to reduce the prevalence of STH to less than 5% by 2020. Burkina Faso does not have a national STH program. STH is covered by the national SCH program, which started in 2004 with financial support from SCI. Strategies to combat STH strategies include: MDA, environmental improvement and sanitation, BCC, advocacy, surveillance and capacity building. Because ALB is used for LF, and LF was endemic in all 70 HDs, STH treatment is provided in the context of the NTD program with LF until a district has stopped MDA. Districts that have stopped LF MDAs then receive ALB with SCH MDA. Districts with no LF MDA and no SCH MDA will not be treated for STH through the NTD MDAs. For FY16, this affects six HDs in the Nord region, but will affect more districts in years to come. Deworming for children 23-59 months is conducted nationwide in tandem with vitamin A distribution twice a year.

Trachoma

Trachoma is endemic in 48 HDs[8] (trachomatous inflammation follicular (TF) prevalence of 5% or more at baseline). 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 improvement) strategy, M&E, BCC, advocacy and capacity building.

Of the 48 endemic districts, 16 were between 5-9.9% at baseline and have never received treatment. Thirty-two districts were ≥10% TF at baseline and have received at least three rounds of MDA. Impact assessments in these districts enabled 27 districts to fall below 10% TF, and consequently, all of those districts stopped MDA. However, there are two districts that are still between 5-9.9% (this was before the new standard operating procedures were developed, which state that districts with 5-9.9% TF at impact may conduct one round of MDA to be followed by impact assessment). Finally, five districts still have TF>10% and are currently under a treatment regimen. Of these, four were scheduled to conduct impact assessments in FY15 but due to the delay in FY15 trachoma MDA, the impact assessments are delayed until November 2015. If they are<5% TF, then MDA will also stop in those districts. The one district that is ≥10% TF and not scheduled for impact assessments in FY15 (Pô) will complete its 3rd round of MDA in its second three-round series in FY16.

[8] Note that this is based on the new number of districts (70 instead of the original 63).

Table 2: Snapshot of the expected status of the NTD program in BURKINA FASO as of September 30, 2015

		Columns C+D+E=B for each disease*			Columns F+G+H=C for each disease*			
		MAPPING GAP DETERMINATION			MDA GAP DETERMINATION		MDA ACHIEVEMENT	DSA NEEDS
A	B	C	D	E	F	G	H	I
Disease	Total No. of Districts in 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 receiving MDA as of 09/30/15	No. of districts expected to be in need of MDA at any level: MDA not yet started, or has prematurely stopped as of 09/30/15	Expected No. of districts where criteria for stopping district-level MDA have been met as of 09/30/15	No. of districts requiring DSA as of 09/30/15
					USAID-funded / Others			
Lymphatic filariasis	70	70	0	0	26 / 5[1]	0	39	Pre-TAS (21)[2] TAS1 (5)[3] TAS2(15)[4] TAS3(11)[5]
Onchocerciasis		6	64	0	4 / 2[6]	0	0	Eval. Epi (7)[7] Eval. Entomo (2)
Schistosomiasis		70	0	0	70[8] / 0	0	0	SS: 19 CS: 42
Soil-transmitted helminths		70	0	0	65[9] / 5	0	0	STH+ SS (19 SS) STH+CS (42 CS) STH+TAS2 (15) STH+TAS3 (11)
Trachoma[10]		48	22	0	5 / 0	18	25	Impact evaluation (10)

1. LF MDA: FPSU-LSTM will cover the operational costs of MDA in the 4 HDs of the Centre-Sud region and the HD of Zabré. In addition FPSU supports one round of MDA in the 5 HDs of the Sud-Ouest and USAID supports the other round.
2. Centre-Sud (8 CS in 4 HDs), Centre-Est (1SS, 6 CS in 3 HDs) ; Est (1SS, 11 CS in 6 HDs) ; Centre (5 CS in 4 HDs), Sahel (2 CS in 1 HD) ; Sud-Ouest (6 CS in 3 HDs)
3. Boromo, Dédougou, Léo, Sapouy Zabré HD (3 EU)

Formatted: Spanish (Dominican Republic)

4. Centre-Nord (6 HDs), Centre-Ouest (5 HDs), Boucle du Mouhoun (2 EU, 4 HDs)
5. Cascades (3HDs), Hauts Bassins (2 HDs), Nord (6 HDs)
6. MDA Oncho in 2 HDs in the Cascades is supported by Sightsavers
7. Sighsavers: Banfora, Mangodara and World Bank: Pama, Diapaga, Fada, Léo, Sapouy. Note that Pama and Diapaga are not currently considered endemic; however, they had been treated through APOC and the NTDP would like to determine whether any transmission is occurring.
8. See Annex 9. All HDs are currently under a treatment regimen on either a twice annual, once annual, or every other year basis. Therefore, not every HDs is treated every year.
9. HDs are treated for STH either via LF or SCH. However, where LF MDA has stopped, and because not all HDs treat on an annual basis for SCH, some HDs are not treated every year for STH. 5 HDs treated only through FPSU-L support for LF MDA (IVM+ALB) (the 4 HDs of the Centre-Sud region and 1 HD in the Centre-Est); all other HDs supported either through LF or SCH support through the END in Africa project. There are an additional 5 HDs in the Sud-Ouest that receive one LF/STH treatment with support from USAID and the other round through FPSU-L.
10. 48 HDs had TF prevalence of 5% or more among children 1-9 years of age at baseline (and some currently still do). These include the 32 previously endemic (prevalence equal to or more than 10%) and 16 of the 38 considered previously non-endemic (because baseline TF not ≥10% but have baseline TF prevalence between 5% and 9.9%. Please note that in the FY15 workplan, the NTDP counted a HD as endemic if the TF prevalence was 10% or greater and there were 32 such HDs, while in FY16 the number of endemic HDs is now 48 based on new World Health Organization (WHO) recommendations. In addition, please note that there are more HDs in FY16 than in FY15 due to redistricting (total of 63 HDs in FY15 versus 70 HDs in FY16). In FY15, only 5 HDs were under treatment and 27 HDs had stopped treatment; however, over the course of FY15, new standard operating procedures (SOPs) for trachoma were developed by the WHO in which HDs with TF prevalence between 5-9.9% warrant treatment. Therefore, there are 2 among the 7HDs that stopped MDA after falling below 10% but have TF prevalence still above 5% (Zabré and Manni) and will again be treated in FY16. An additional 16 HDs were between 5-9.9% at baseline but have never been treated. Eighteen HDs will be treated in FY16 for the first time (2 of the 27 HDs that had stopped MDA plus 16 HDs that were considered previously non-endemic but have baseline TF prevalence 5-9.9%), to be followed by an impact assessment at least 6 months later. Due to the timing of the MDA (March 2016) and the fact that impact assessments should take place at least 6 months following the MDA (September 2016), only a proportion of the impact assessments will take place in FY16; the others will be conducted at the beginning of FY17 (October 2017).

PLANNED ACTIVITIES

Project assistance

The following activities are scheduled for 2016 with USAID funding. All will be covered under an agreement with the central and regional levels of health, pursuant to the FOG process.

- Train trainers, supervisors, supply chain actors and community drug distributors (CDDs) that are involved in implementing NTD MDA activities at all levels of the health system to ensure high coverage during the MDA, accurate reporting of data, and correct doses given to the target population.
- MDA SCH in 59 HDs (all with END in Africa support)
- MDA LF in 31 HDs (5 uniquely with FPSU-L support and 5 with one round with USAID support and one round with FPSU-L support)
- MDA Oncho in 6 HDs (2 with Sightsavers support)
- MDA Trachoma in 23 HDs (all with END in Africa support)

- MDA STH in 64 HDs (5 with FPSU-L support only and 5 with 1 round with USAID support and the second round with FPSU-L support)
- Pre-TAS in 21 HDs (7 with USAID support ; 7 with World Bank support ; 7 with FPSU-L support)
- TAS 1 in 5 HDs (1 with FPSU-L support)
- TAS 2+ STH in 15 HDs (all with USAID support)
- TAS 3+STH in 11 HDs (all with USAID support)
- Trachoma impact assessments in 10 HDs (3 with World Bank support)
- Surveys in 21 SS in 19 HDs (END in Africa support) and 42 CS (World Bank support) for SCH/STH
- Supply the health facilities (Regional Health Directorate (Direction Régionale de la Santé or DRS-HD-CSPS) with drugs and data collection and IEC materials.
- Supervise actors during implementation of MDA campaigns at all levels.
- Administer drugs to the target populations (by the distributors) during MDA campaigns.
- Reproduce the data collection tools for managing and reporting information during MDAs.
- Collect data from NTD MDA campaigns at all levels.
- Hold integrated review meetings for MDA campaigns at the regional level.
- Conduct management audits of NTD drugs.
- Conduct M&E for all 5 targeted NTDs.
- Conduct communications and social mobilization activities at all levels of the health system.

There are no specific activities for gender equality and female empowerment in the following annual work plan. However, during MDA, many of the messages are specifically targeted towards women, either because they may be more at risk of a disease (trachoma) or because they are the primary caretakers of children, and the principal population at-risk for other diseases (SCH and STH). In addition, the program plans to prioritize women in selecting additional trainers, supervisors, and community distributors.

Strategic Planning (Location in Budget: ODC)
The FY2016 activities of the NTDP are determined according to the program needs informed by disease prevalence and results of impact assessments (where available) at the end of the FY2015 implementation period, as well as new recommendations from the WHO. For example, in 2015, the WHO issued new standard operating procedures for trachoma, in which elimination is now achieved at the district level instead of the sub-district level and districts where TF between 5-9.9% among children ages one to nine years now warrant one year of MDA to be followed by impact assessment. These changes to operating procedures have necessitated changes to Burkina Faso's trachoma elimination plans. In addition, the NTDP held an LF strategy review meeting in August 2015. Updates to the FY16 operational work plan may be necessary following the review of the LF elimination strategy and following the development of the NTD program's 2016-2020 strategic plan.

In January 2014, the main NTDP and HKI personnel participated in TIPAC training provided by Deloitte. There were problems with the 2015 TIPAC update and, as a result, not all of the 2015 activities could be entered in the planning and budget forecasting software during the period concerned. After two successive years of attempting to utilize the tool and encountering difficulties in doing so, the NTD program determined that it would suspend its usage in FY16.

The current national NTD strategic plan covers the period 2012-2016. The NTDP action plan calls for revising the 2012-2016 strategic plan in 2015 to cover the period 2016-2020, including an assessment of

the 2012-2016 plan. The assessment will examine the level of execution of the planned activities, the principal results, and the strategies used. For the new planning process, the WHO has given some guidance which will need to be incorporated into the new plan. USAID funding will be sought to develop and validate this plan.

Pursuant to the standard planning process, a workshop to develop the FY17 annual work plan will be held during the period May-June 2016. All stakeholders will then validate it.

In 2015, the NTDP established a technical committee and steering committee (see Appendices 10 and 11). Pursuant to the decrees that created these two bodies, the national steering committee will meet biannually and the technical committee will meet quarterly. The average length of each meeting will be two days.

These committees are responsible for, among other tasks, determining the major directions for joint implementation of the activities and providing technical opinions on proposals from the NTDP coordination by referring to national and international recommendations on controlling and combatting NTDs in Burkina Faso. These committees require technical and financial support from the END NTDs in Africa project to operate.

NTD Secretariat (Location in Budget: ODC)
Burkina Faso's NTD Coordination will seek operating support from USAID in 2016 through the following:

- two laptop computers for the NTD coordination, as the number of M&E personnel has increased from one to four persons and not all personnel currently have computers;
- one overhead projector, as the NTDP's current overhead projector is no longer in a useable condition;
- support for communications and Internet access;
- twenty-five cameras to supplement the NTDP's current cameras, since program activities have increased and it is important to document the implementation of these activities; and,
- Office supplies and consumables, such as printer paper, folders, ink and other consumables necessary for printing.

Advocacy (Location in Budget: FOG, ODC)
Advocacy activities will be implemented by different levels within the health system.
At the central level, health officials from the central directorate, as well as the WHO and partners of the NTDP, will travel to the field for the launch of the MDAs. This field visit will receive considerable media coverage, thus helping to:

- Ensure the campaigns' visibility;
- Inform the public about the importance of efforts to control NTDs;
- Ensure that top Ministry of Health officials and regional and local officials are mobilized during the campaigns;
- Reassure the populations as to the effectiveness and safety of the drugs used during the campaigns; and,
- Encourage the CDDs in their efforts to implement the campaigns.

At the regional level, an advocacy day targeting the administrative, traditional and religious authorities will be held in all regions implementing MDA before the first MDA begins to ensure their participation in and commitment to NTD control activities. A total of 12 advocacy days will be organized in 2016.

At the HD level, an information and public awareness day will be held for the political, administrative, traditional and religious authorities during each MDA.

The site chosen for the field visit to launch the MDA campaigns will be a site where either prevalence is still high after multiple rounds of MDA and where evaluations indicate that MDA must continue, or where treatment coverage is lowest.

To achieve the expected results, financial resources to implement the communications activities will be available at the central level at least three months before the MDA campaigns begin. Materials can thus be reproduced and delivered to the regions at least three weeks before the start of each campaign. The IEC activities should begin at least two weeks prior to implementation of each MDA at the intermediary and peripheral levels.

Social Mobilization (Location in Budget: FOG)
At the central level, the needs for communication tools and activities to be implemented for public awareness campaigns are as follows:

- Develop, reproduce and distribute, to the regions, health districts and health facilities, brochures and posters on the NTDs that are the focus of control efforts. A total of 11,475 brochures will be reproduced as follows: (i) LF = 2,050; (ii) Oncho = 1,500; (iii) SCH = 4,550 and (iv) Trachoma = 3,375. In addition, 15,129 posters will be reproduced, broken down by disease: LF = 3,545; Oncho = 1,698; SCH = 7,500; and Trachoma = 2,386;
- Produce three TV spots (LF, SCH, trachoma);
- Produce three radio spots (LF, SCH, trachoma);
- Broadcast the spots 36 times (12 per NTD);
- Broadcast the radio spots 60 times (20 by disease) on national channels;
- Broadcast two films on LF on the national channel;
- Broadcast one film on oncho on the national channel. The national channel was selected since the two regions endemic for Oncho do not have their own channels;
- Produce two TV and radio sketches on SCH and trachoma;
- Broadcast two TV sketches (SCH and trachoma) and two radio sketches on the national channels; and,
- Make 20 DVD copies of the oncho film.

At the regional level, the public awareness campaign needs are as follows:

- Produce a French-language radio broadcast during each MDA conducted in the region; and,
- Produce one French-language spot and three spots in the region's top two or three local languages on the NTDs covered by the MDA campaign. For example, in the Centre region, the languages will be Mooré, Dioula, and Fulfuldé; in the Ouest region, Bobo, Dioula, and Fulfuldé; in the Est region, Gourma, Mooré, and Fulfuldé; in the Sahel, Fulfuldé and Mooré; and in the Centre Est region, Bissa, Mooré, and Fulfuldé.

At the HD level, the following activities will be carried out as part of the public awareness campaigns:

- Produce and broadcast a program in the leading language in each HD during the MDA;
- Broadcast the spots produced by the DRS 20 times for each MDA;
- Broadcast the radio program produced by the DRS once for each MDA; and,

- Hold two screenings of the LF video and two screenings of the oncho video in the low-coverage (<75% epidemiological coverage) villages in 30 HDs for LF and six HDs for oncho.

At the health center level, communications plans will be developed and incorporate the following activities:

- Inform and raise awareness among local political, traditional religious and administrative authorities during each MDA;
- Raise public awareness of the dates and the importance of the MDA with the help of public criers.

At the community level, information and grassroots public awareness activities will be carried out with the help of the community organizers and CDDs. These types of activities include household visits and visits to mosques and churches to ensure that the population is aware of the MDA.

Implementation of the communications and public awareness activities will incorporate the outcomes of the previous MDAs:

The materials described above (brochures, posters, etc.) will be reproduced again in FY16. These materials have a significant impact on the population's participation in the MDAs. The materials will be used again this year to support advocacy and communications activities.

Development of the messages incorporated the successes and problems encountered during prior campaigns. For example, the messages will give information about minor secondary effects, as well as other facts on the importance of MDA to counteract other reasons given for refusing to participate in the MDA. The messages will also make mention of successes, such as high participation will lead to elimination of diseases (in the cases of LF, oncho, and trachoma).

Radio and television programs will be broadcast and will provide information on the disease and the problems encountered during the prior campaigns, such as information to help counteract reasons given for refusal. For example, the programs will provide information on minor secondary effects to try to decrease the number of persons refusing to take part in the MDA. The film screenings had a positive impact on treatment coverages in previous years; they will be held again in 2016 in the areas that recorded low coverage during the prior MDAs.

The radio and TV spots at the central level will use four languages. French is the official language of Burkina Faso and the three national languages are Mooré, Dioula and Fulfulde. However, the radio and TV magazine programs will use other local languages in addition to those four, based on the location and audience targeted. French and a given district's three most common local languages will be used at the intermediary and peripheral levels.

The methods used to measure the public awareness efforts include:

- Surveys of the population's Knowledge, Attitudes and Practices (KAP) regarding NTDs, which are combined with treatment coverage surveys. The surveys include questions that provide information on how most people are obtaining information about the MDA and whether the social mobilization methods influenced decisions to participate in MDA. Suggestions are also gathered during these surveys to improve communications for future campaigns.
- Community self-monitoring (CSM) conducted after the MDA for oncho helps to assess the population's knowledge of the disease and public participation in oncho elimination actions. CSM is

the process by which the community itself monitors the progress of MDA through holding community meetings and asking for feedback on the way in which the MDA was conducted and what can be done to improve the MDA.
- In addition to combining the KAP surveys with the coverage and CSM surveys, specific IEC/BCC data collection tools will be developed. They will be used to monitor the activities during the MDA and document successes and tools in need of improvement.

To address rural residents' low literacy levels when using posters and brochures, these materials will be designed to ensure that images alone transmit the messages. A pre-test of the materials with the beneficiaries will be conducted before validating the final document. If the pre-test of these materials indicates that the messages are not being understood, the materials will be revised.

Capacity Building/Training (Location in Budget: FOG)
Several training and capacity-building sessions were identified as necessary for the 2016 action plan. They include:

- **National level:** Hold a training session for **56** trainers on MDA campaign implementation. Trainees will include personnel from the 12 regions implementing MDA and staff from the NTDP team. Topics will include MDA monitoring and supervision; supply chain management (SCM) and SOPs for NTD MDAs; managing side effects; community mobilization; and completing reporting forms following MDA implementation.
- **Regional level:** Hold training/refresher sessions for **229** regional and HD personnel on MDA campaign implementation. 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:** Organize training/refresher sessions for **1,593** head nurses (ICPs) on conducting the planned MDA campaigns. 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.
- **CSPS level:** Hold a training/refresher session for **27,098** CDDs (LF: 17,664, including 934 urban distributors (UD) in urban areas; SCH: 4,212 for the first round and 567 for the HDs with a second round; trachoma: 1,863; oncho: 1,858) on implementing the planned MDA campaigns. 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.

The following training sessions will be held as part of M&E activities:

- Training/refresher sessions for 13 ophthalmic assistants over two 3-day sessions on the trachoma impact assessment methodology in 10 HDs (Po, Nanoro, Léo, Réo, Tenado, Houndé, Nongrmassom, Sindou, Tougan and Dédougou).
- Train 1,901 health workers and CDDs at the regional, district, health center and village level of the Sud-Ouest HD on CSM to empower communities to help monitor the MDA and provide solutions for problems that occur during MDA.
- Training on data quality assessment (DQA) for 102 NTDP and Center for Health Information and Epidemiological Surveillance (CISSE) members in the regions. The CISSE are responsible for analyzing MDA data prior to sending them to the NTDP. This training will enable them to conduct evaluations of the data that are transmitted so that they better understand where potential data errors occur. The training will be led by two trainers of trainers (members of the NTDP who were trained in a WHO-led training in FY15).

Supervision will be provided at all levels to ensure that the actors trained maintain their skills. For example, to ensure that the MDA training was carried out well, the NTD coordination will lead supervisory visits to the field during each MDA campaign. Supervisors will use supervisory checklists to ensure that consistent data are collected and that a comprehensive supervision was completed. The data collected will be discussed during the MDA evaluation meetings. This type of supervision will be carried out in a cascade fashion, with the central level supervising the region level, the region supervising the district, etc.

To ensure that training for the ophthalmic assistants for the trachoma impact assessments was carried out correctly, supervisory teams will follow the WHO SOPs and check a sample of cases deemed positive by the graders to ensure that graders are correctly identifying TF and TT.

Table 3: Training targets

Training Groups	Training Topics	Number to be Trained			Number Training Days	Location of training (s)	Name other funding partner (if applicable, e.g., MOH, SCI)
		New	Refresher	Total trainees			
Integrated training of central-level trainers on conducting MDAs	- MDA/CDTI implementation - MDA/CDTI monitoring and supervision - SCM and SOP for MDA/CDTI drugs - Management of side effects - Social mobilization - Filling out MDA data collection tools	0	56	56	2	Ouagadougou	
Integrated training of DRS- and district-level trainers on conducting MDAs		0	229	229	2	DRS	
Integrated training for ICPs on conducting MDAs		0	1593	1593	2	Districts' administrative centers	

Training Groups	Training Topics	Number to be Trained			Number Training Days	Location of training (s)	Name other funding partner (if applicable, e.g., MOH, SCI)
		New	Refresher	Total trainees			
Training for CDDs and health workers for **LF**	- Using measuring poles - Giving drug - Recognizing side effects - Social mobilization - Filling out MDA data collection tools	0	17664	LF: CDDs= 16730 UD=934	2	CSPS	FPSU-L will support 4,206 CDDs 197 UD
Training for CDDs and health workers for **SCH**		0	4779	SCH: 1st round 4212 2nd round 567	2	CSPS	The World Bank will support 1,800
Training for CDDs and health workers for **TRACHOMA**		0	1863	Trachoma: 1863	2	CSPS	The World Bank will support 1,700
Training for CDDs and health workers for **oncho**		0	1858	Oncho : 1858 on CDTI	2	CSPS	Sightsavers will support 596
Training in community self-monitoring	- CDTI strategy - CSM techniques - IEC/BCC Data collection tools	0	1901	1901	4	Sud Ouest region	
Training/refresher sessions on conducting surveys for ophthalmic assistants	- Survey methodology - Filling out data collection tools - WHO trachoma coding	0	13	13	3	DRS	
DQA training	- DQA concept - DQA objectives - DQA methodology Applying DQA protocol	102	0	102	5	DRS	

Mapping (Location in Budget: not budgeted)
Mapping has already been conducted at national scale for schistosomiasis, LF, trachoma and onchocerciasis.

MDA (Location in Budget: FOG)
In 2016, MDA take place in 12 health regions (64 HDs) targeted by the NTD program for MDA. For each disease the following number of HDs will be targeted for MDA (the number of HDs listed reflects the new districting scheme of 70 HDs, versus the 63 HDs in previous workplans): (i) LF=31; (ii) SCH=59; (iii) STH=64; (iv) trachoma=23; and (v) oncho=6.

MDA will cover 100% of the HDs targeted for LF, oncho, SCH, and trachoma. Certain HDs will not receive SCH or STH MDA in FY2015 as explained in the table notes under Table 2, as, according to the National NTDP strategy, deworming only occurs in HDs targeted for LF or SCH MDA and not as a separate activity.

The drug distribution strategies for the target populations are as follows:

Distribution of IVM + ALB: One round of MDA will be conducted in 26 HD with END in Africa support and 5 HDs will be treated uniquely with FPSU-L support. In addition, 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%). The first of these rounds is financially supported by the END in Africa project; and the second by FPSU-L. These 4 HDs are counted among the 26 with USAID support. The total target population is 4,721,201.

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 over at least six days. This period may be extended if the expected coverage is not achieved. Tablets are administered to the populations door-to-door in villages, sectors, health centers, military barracks, schools and field-to-field in farming hamlets. Specific treatments for populations at gold mining sites or specific gathering sites will be provided to improve treatment coverage. To increase drug acceptance among urban populations, health workers will carry out the distributions in those areas. This reduces considerably the number of individuals who may refuse/be reluctant to take drugs during the MDA campaigns.

Distribution of PZQ tablets: For SCH, the NTDP held a review meeting of experts in November 2013 in Ouagadougou. The SCH treatment strategy was aligned to WHO recommendations following a review of the baseline survey data and data from other follow-up studies on SCH. This resulted in a treatment strategy where 7 HDs receive treatment twice per year; 10 HDs receive annual treatment; and 53 HDs receive treatment once every other year. A total of 59 HDs are targeted for MDA in FY16 with a total target population of 10,890,322 (note that 2,568,500 SAC are targeted for two annual rounds). All MDA for SCH in FY16 will take place with support from the END in Africa project.

Health workers distribute these tablets in villages/sectors. These health workers/drug distributors generally do not live at the sites. They are thus always accompanied by community volunteers or community health workers, who do live in the areas targeted for treatment. The latter are considered guides and organizers, helping to reach the greatest number of people targeted for treatment. After many adverse side effects were noted at the start of the program, the decision was made to assign health workers to distribute praziquantel, as the use of health workers in distributing the drug better ensures that minor and severe adverse events will be recognized and managed correctly. This also better ensures population compliance with the MDA. Drugs are distributed door-to-door within the communities, agencies and schools and field-to-field in farming hamlets.

Distribution of azithromycin + 1% tetracycline eye ointment: For trachoma, 23 HDs warrant MDA in FY2016 with a total target population of 5,716,036. This is primarily due to the new standard operating procedures validated by the RPRG in 2015. These new standard operating procedures state that districts with a prevalence of TF between 5-9.9% may be treated for one round of MDA to be followed by impact assessments. Only one HD currently under a current three year treatment plan will warrant MDA in FY16 (Po). All MDA support for trachoma will be through END in Africa. To note, the TEO 1% has historically been purchased by the Government of Burkina Faso. However, in FY15, the government budget was reduced, including the NTD program line. Therefore, the NTDP was unable to purchase the TEO as needed for the MDA and solicits an exception by USAID on the drug-purchasing regulation that will enable the NTDP to purchase TEO through the END in Africa project.

As in the MDA for SCH with praziquantel, health workers distribute these tablets, suspension, and eye ointment at each village/sector. These health workers/drug distributors generally do not live at the sites and are accompanied by community volunteers or community health workers, who live in the areas targeted for treatment. The latter are considered guides and organizers, helping to reach the greatest number of people targeted for treatment.

Distribution of IVM for OV in the Cascades and IVM+ALB for LF and OV in the Sud-Ouest:
For Oncho, 6 HDs currently require MDA with an at-risk population of 233,703 and targeted population of 186,615. 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.

Distribution is conducted twice annually in six HDs in two regions (Cascades and Sud Ouest) using the CDTI platform. IVM is distributed in the Cascades while IVM+ALB are distributed in the Sud Ouest region. The MDA will continue in these two regions in 2016. A door-to-door distribution strategy is used for households in each endemic village/hamlet. Each CDD has an oncho treatment register that lists individuals' identity by household. The MDA in the Cascades region will be conducted with financial support from Sightsavers. USAID/HKI will support the distribution in the Sud Ouest region. CSM will be used in 2016 in the six HDs that conduct MDA for oncho to improve treatment coverage and will allow the communities concerned to take ownership of the treatment.

Distribution of IVM+ALB or PZQ+ALB for STH: For STH, all 70 HDs are endemic and are on treatment schedules either through LF (IVM+ALB) or SCH (PZQ+ALB) MDA. In FY2016, 64 of these HDs will receive MDA; 59 with financial support from the END in Africa project and five through FPSU-L. The four HDs in the Centre-Sud region (Kombissiri, Manga, Po, and Saponé) and Zabré HD in the Centre-Est will be supported by FPSU-L.

The principal partners for MDA, after USAID through the END in Africa project, include:

Sightsavers: Support to Oncho MDA in 2 HDs in the Cascades region

DFID via FPSU-L: Financial and technical support to carry out LF MDA in the Sud Ouest (4 HDs), Centre Sud (4 HDs) and Centre Est (Zabré HD).

World Bank: Financial support to implement efforts to combat NTDs (in addition to some funds for MDA training, additional incentives for the CDDs and communications and supervision activities) in the MDA districts, with support being prioritized in districts bordering Niger and Mali.

Social mobilization efforts for MDA are described above in the "Social Mobilization" section.

Table 4: USAID-supported districts and estimated target populations for MDA in FY16

NTD	Age groups targeted (per disease workbook instructions)	Number of rounds of distribution annually (add additional rows for different treatment frequencies)	Distribution platform(s)	Number of districts to be treated in FY16	Total # of eligible people targeted in FY16
Lymphatic filariasis	Entire population >5 years	1	Community-based distribution	26	4,721,201
Onchocerciasis	Entire population >5 years	2	Community but CDTI	4	144,250
Schistosomiasis	Children between 5-14 years and high-risk adults	1	Distribution by health workers	24	5,788,152
	Children between 5-14 years and high-risk adults	2	Distribution by health workers	7	2,568,500
	Children between 5-14 years	1	Distribution by health workers	28	2,533,670
Soil-transmitted helminths	Children between 5-14 years	1	Community-based distribution and health workers	64 (STH/ FL/=31; STH/ SCH=33)	5,132,952 (STH/FL= 1,701,416; STH/SCH= 3,431,536)
Trachoma	0-6 months	1	Distribution by health workers	23	114,321
	6-59 months				1,028,886
	Over 5 years				4,572,829

MDA Challenges

Table 5: Explanation of low USAID-supported program and epidemiological coverage

NTD	Epi coverage targets	Number of districts with complete coverage information*	Number of districts that did not meet coverage targets*	Reason(s) for poor district performance	Proposed remediation actions (bulleted list, with detailed narrative below table)
Lymphatic filariasis	>= 65% epid. coverage	41	Epidemiological: 0		
		41	Program: 7[9]	- Insufficient incentives for the CDDs - Unfavorable distribution period (rainy season) - Insufficient number of CDDs and UDs - Mobility of cross-border populations - Reluctance to take treatment because of fear of side effects	- Increase financial resources allocated to the health districts for increased supervision; - Increase the number and incentives of CDDs; - Organize MDA campaigns between January and March; - Synchronize MDA campaigns with neighboring countries (Ghana and Cote d'Ivoire); - Strengthen IEC/BCC
Oncho	>= 65% epid. coverage	6	Epidemiological: 0		
		6	Program: 5	- Lack of awareness (insufficient activities and IEC/BCC materials) - CDTI data collection materials not completed adequately -Unfavorable distribution period (rainy season) -Population mobility (including gold mining sites and neighboring countries) -Inadequate distribution of CDDs	- Strengthen the BCC (provide IEC/BCC materials, hold educational talks, produce broadcast magazines and screen films) -Strengthen supervision of the CDDs -Improve CDD training - Organize MDA campaigns between Jan and March; -Deploy CDDs at gold mining sites - Synchronize MDA campaigns with neighboring countries;

[9] Range of low program coverage: 65.0 -79,9%

SCH	>= 75% epid. coverage of school-age children	44	Epidemiological: 0		
		44	Program: 0		
STH	>= 75% epid. coverage of school-age children	41	Epidemiological: 0		
		41	Program: 0		
Trachoma	>= 80% epid. coverage	5	Epidemiological: 0		
		5	Program: 0		

* Given the lack of available data on epidemiological and programmatic coverage for the 2015 MDAs, the table uses 2014 MDA coverage data.

The main challenges of MDA include:

- The availability and storage of azithromycin in order to carry out trachoma MDAs in the 23 HDs, as azithromycin takes up more storage space than the other NTD drugs, primarily due to the syrup, for which each bottle makes an average of only three doses. Burkina Faso has had issues over the years finding enough storage space for drug, and with a jump from 5 HDs under MDA for trachoma in FY15 to 23 HDs in FY16, this will be a major challenge for the NTDP to overcome.
- Conducting impact assessments within the appropriate timeframes after a treatment round to determine whether to stop or continue the MDA. This has primarily been an issue for the TAS with the ICT cards, where shipment times can widely vary, making it difficult for the NTDP to plan.

The primary reasons for poor district performance include:

- The compensation given to CDDs is quite low. The same persons are used by other programs, such as nutrition, malaria, vaccination and have expressed that the workload for NTDs is much greater than that of the other programs but that they receive less compensation for the work. This means that turnover by CDDs is high and drug distribution may not be prioritized by some CDDs.
- For the LF MDA, the MDA period was not the best time of year, as it was conducted during the rainy season. This was because the drug had not arrived in-country at the time that the NTPD planned to do the MDA. The rainy season is not ideal for a number of reasons, including the fact that parts of the population leave their home villages to move to farming hamlets, which increases the workload on CDDs and accessibility may not be easy or even possible. In addition, the CDDs themselves may not be available as they are working in their own fields.
- The numbers of CDDs and UDs is less than required. The NTDP must do a theoretical calculation during work planning based on the overall target population. However, in reality, the density of the population varies significantly, and this leads to some CDDs needing to walk many kilometers in order to reach the targeted number of persons.
- In certain areas, some populations have been reticent to participate in the MDA due to having experienced minor secondary effects (headaches, diarrhea, vomiting) in previous MDAs.

- In some cases, the number of IEC materials has been underestimated during planning and does not reach the entire target population. In addition, some social mobilization activities, such as radio broadcasts, were not carried out during the last MDA.
- Due to the low levels of education of most CDDs, correct reporting is a challenge. For example, during supervision, supervisors detect CDDs who have not correctly or completely filled out their treatment registers.
- In Burkina Faso, certain populations are mobile and travel to gold-mining sites and neighboring countries to find work, and there also exists a large nomadic population. This can mean that a significant proportion of the population requiring MDA may not receive it, depending on the season and dynamics of the population movements.

In order to improve coverage, the NTDP plans the following for the FY16 MDA:

- Increase the funding allocated to each HD for supervision in order to better allow the supervisors to detect and resolve issues
- Increase the compensation given to CDDs with support from the World Bank
- Organize the MDA campaigns between the months of January and March 2016, which is the dry season and after the harvest is complete.
- Synchronize MDA with neighboring countries by organizing meetings with neighboring countries to discuss MDA schedules
- Reinforce IEC/BCC strategies by ensuring that enough materials are produced and distributed, implementing educational talks and projecting the films produced for the NTDP in areas with known coverage problems
- Improve the training of CDDs by including a practical phase in the training, including a field visit to simulate an MDA setting
- Send CDDs to gold-mining sites to distribute the MDA drugs

Lessons learned from previous campaigns have allowed the NTDP to identify the following actions in order to increase MDA coverage:

- Supervision needs to be increased, particularly in areas with low coverage; therefore, in FY16, the supervision budget at the district level was increased
- Gold-mining sites and farming hamlets should be identified prior to the MDA in order to send CDDs to these areas to distribute drug and ensure that drug is distributed to those in the target population in these areas
- Produce films on the importance of taking the medications during the MDA campaigns
- Broadcast messages in local languages about precautions needed when taking MDA drugs to decrease the likelihood of side effects, such as eating prior to taking the MDA drugs, not taking the medication with alcoholic beverages, etc.
- MDAs need to be conducted during the appropriate period of year (January to March)

Drug and Commodity Supply Management and Procurement (Location in Budget: FOG, ODC)
The national NTD control program coordination is responsible for quantifying the country's NTD drug needs. This is done based on:

- The NTD program's annual objectives;
- The projected number of people to be treated/year;

- The drug supplies in the country at the time of the order (supplies remaining from prior campaigns through a physical inventory conducted at each level following the MDA); and,
- The planned product delivery time (the drugs need to be ordered at minimum six to eight months prior to the planned MDA dates).

In order to quantify the amount of drug to order, the central level is notified of the regions' needs and consolidates that information to determine the country's overall needs. The method for determining drug quantification methods for each NTD is determined by the eligible population (which differs by disease; for example, for trachoma, 100% of the population is eligible for MDA but 2% of the population are estimated to need TEO, 18% to need the Zithromax syrup, and 80% for Zithromax tablets). In addition, the amount of drug currently in country is subtracted from the overall need to arrive at the drug needed to order.

In 2014, the program received technical assistance from JSI, which helped to strengthen the skills of 120 pharmaceutical logistics workers in the area of NTD drug supply management. This training, which covered all 11 logistics components, included methods to improve quantification.

Joint requests

Joint requests for NTD products are submitted six to eight months prior to product delivery. The WHO joint form is used to obtain Mectizan and albendazole, the USAID form is used for praziquantel and the ITI form is used for Zithromax. For the next PZQ order, the joint request form will also incorporate the request for PZQ. In the past, TEO for trachoma has been purchased through the NTD budget line in the Government of Burkina Faso's budget; however, in FY15, following the forced resignation of then President Blaise Campaoré, the NTD budget line was reduced and administrative procedures changed, making it very difficult to access the NTD funds. Therefore, for FY16, the NTDP requests funds from USAID to fund the TEO.

Transport

The program receives financial support from END in Africa to transport drugs from the central level to the regional directorates for all PC NTDs and from the regions to the HDs.

The shipping, transport and delivery of NTD drugs to the distribution sites follow the steps below:

- MDA drug supplies are inventoried at all levels (CSPS, district, region);
- Drug distribution schedules are drawn up prior to providing the supplies;
- Regions are supplied by the NTD program coordination;
- The regional pharmacies supplies the HDs with drug and other supplies, such as dosing poles; and,
- The health centers are supplied by the districts' pharmacy service.

Warehousing and storage in the country

The guidelines for NTD product storage that apply to district, regional and central warehouses are identical to those for the storage of other health products. NTD product storage instructions are as follows:

- Avoid exposing the drugs to sun and heat;
- Protect the drugs against high temperatures during transport in a truck or heavy goods vehicle;
- Protect the drugs from water and rain;
- Find temporary storage space close to the location where the MDA will be carried out;
- Drugs are kept in secure warehouses that are locked and guarded

From 16 April – 8 May 2015, the program received technical assistance from JSI, with post-training evaluation visits. This process revealed that 75% of the facilities visited – from the central level to the operational level – have limited storage capacity. It also highlighted that the drug logistics managers (primarily pharmacists and pharmacist assistants) need to strengthen their capacity to deal with congestion and reorganization to optimize the use of storage space (see Short Term Technical Assistance section).

Management of unused or expired drugs
Drugs are managed within the program based on lot number and expiration date, in accordance with the guidelines in the procedure manual for managing drugs and other supplies for NTD control efforts. The program has not registered any expired drugs over the last three years. However, tools were created through the NTDP to manage damaged, unusable or expired products in compliance with national guidelines. Any such products are destroyed during post-MDA logistics audits.

Products that require refrigeration infrastructure
The program receives heat-sensitive products and consumables each year, most importantly the ICT cards, which must be stored between 2-8° C. In prior years, the program always asked another Ministry of Health department to store these reagents. In recent years, there has been increasingly less space available for the other programs, which explains the need to acquire cold chain equipment. However, for FY16, the NTDP will be able to access cold storage within the vaccination program's cold storage areas.

No technical assistance is planned for 2016 in managing adverse events and serious adverse events (SAE). However, the NTDP will revise its guidelines for SAE management based on the new WHO guidelines.

Supervision (Location in Budget: FOGs, ODC)
Supervision is conducted at all levels of the health system for each activity related to NTD control efforts (MDAs, monitoring/evaluation). Each health facility (central level, regional level, health districts and CSPS) receives funding in accordance with the budget line adopted in the FOG award. These resources include per diems for the supervising health workers and fuel for travel. Based on recommendations from MDA evaluation meetings, vehicle rentals will be provided to the central level to ensure that they can visit the field to supervise MDA. In addition, the technical and financial partners will participate in supervising the actors during the MDA campaigns. The main objective of these supervision visits is to ensure the quality of the campaigns' organization and implementation. Information is thus collected according to the supervisory guides and checklists developed. MDA evaluation meetings following each MDA provide an opportunity to discuss performance achievements and shortcomings and make recommendations to improve the next MDA.

The following activities are planned and will help to identify and address any problems and bottlenecks:

- Supervision will help to assess the actors' performance in carrying out the MDAs and resolving problems identified at all levels;
- Periodic data monitoring during MDA implementation will help to identify bottlenecks and take corrective action;
- A supervision debriefing meeting during the campaign provides an opportunity to make decisions on corrective measures; and,

- The outcomes and experiences of earlier supervision activities will be used to anticipate solutions to problems during the campaigns.

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

- Data collection tools will be provided in accordance with national procedures and WHO protocols at all levels;
- Supervision, which is carried out in cascade formation from the central level down to the CSPS level, will help to ensure that the implementation directives and instructions on completing the data collection tools are available and implemented at all levels during the MDA;
- The instructions for completing the data collection tools will be presented at the MDA training sessions held for all personnel involved at the different levels (regions, HDs, CSPS, CDDs) ;
- Support provided by the NDTP coordination teams to the training sessions will help to ensure that the content of the training provided is consistent with NTDP guidelines; and,
- Participation by HKI teams in the training sessions and activity monitoring will provide an opportunity to emphasize the partners' data collection requirements for completing the workbooks.

Short-Term Technical Assistance (Location in Budget: Not specifically budgeted)

Table 6: Technical Assistance request from END in Africa

Task-TA needed (Relevant Activity category)	**Why needed**	**Technical skill required; (source of TA (CDC, RTI/HQ, etc.))**	**Number of Days required and anticipated quarter**
Support to review the STH control strategy	Identify strategies appropriate and specific to intestinal worm control efforts in connection with WHO standards	Expertise in intestinal worm control efforts	3days January-March 2016
Support to carry out the TAS surveys with the FTS	Availability of a new FTS test that is more reliable than the ICT card. This test will be used going forward for the TAS1 surveys, which begin in 2016	Expertise in the use of the FTS: NTD Support Center Atlanta	7 days January-March 2016
Skills-building support for two biomedical technicians	New personnel assigned to the program, unfamiliar with NTD-related laboratory procedures and techniques	NMIR in Accra	7 days September - November
Support for	Problems associated	Pharmaceutical	

training in addressing congestion and reorganization to optimize storage space	with limited storage capacity, from the central to the operational level	logistics facility or resource person	5 days January-March 2016
Support to conduct DQA	Ensure the quality of data reporting	Expertise in conducting DQA on NTDs (WHO, RTI, NTD Support Center, HKI)	10 days (after the 2nd 2016 MDA)
Support to updating the Workbook databases for the END in Africa project and capacity-building in managing the database	Quality assurance for the data in the workbooks	FHI 360	5 days (1st quarter FY16)
Support to implementing a sustainable mechanism for mobilizing resources	Ensure sustainable financing for the NTD Program activities	Deloitte	Two phases of 3 days each in the 2nd Quarter FY16

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

- An expert review of the STH control strategy: In Burkina Faso, only 31/70 HDs will continue MDA for LF in FY16 and all HDs are expected to meet stop MDA criteria by the end of FY17. As STH is treated first through LF (IVM+ALB), the NTDP needs to determine its strategy moving forward, until the NTDP objectives can be achieved.
- Support to carry out the TAS surveys with the FTS: Burkina Faso has carried out a number of TAS 1, TAS 2 and TAS 3 surveys to date, but all using the ICT cards. As Burkina will be making the switch to FTS in certain HDs in FY16, it is important that the LF unit is capable of correctly using the new test strips to ensure valid results.
- Skills-building support for two biomedical technicians: the NTDP has new laboratory technicians unfamiliar with LF and SCH/STH laboratory techniques.
- Support for training in addressing congestion and reorganization to optimize storage space: the NTDP has repeatedly expressed the issue of storage for the NTD drug. Therefore, TA is requested on optimizing available space in lieu of requesting funds for building new warehouses or paying for additional storage.
- Support to conduct DQA: the NTDP would like to conduct a DQA in FY16, and is seeking training prior to the DQA to enable it to be carried out successfully.
- Support to the national program and project partners in updating the Workbook databases for the END in Africa project and capacity-building in managing the database. A working/capacity building

session with FHI360 is proposed to: promote the importance of finalizing workbooks through reinforcing the need for and use of complete, correct, validated program and project data. The FY13 and FY14 workbooks are still under review and revision, and the FY15 needs to be finalized as soon as reports from all districts have been received. The TA would support a workshop/working session to convene the appropriate NTD program disease focal points, HKI-BF, and FHI360 (and ENVISION, if needed) to review and correct the workbooks for final submission and approval.

- Support to implementing a sustainable mechanism for mobilizing resources: the NTDP does not have experience or knowledge of approaching donors for funding outside of partner NGOs. However, resources are available in-country and USAID funding is only extended through FY18; therefore, the NTDP has expressed a need to learn how to mobilize resources itself.

M&E (Location in Budget: FOG, ODC)

Data Quality and Integrated Database

There were several problems in collecting and transmitting reports from the earlier MDAs. They include:

- Delayed transmission of the reports (promptness), particularly from the district to the regional level and the regional level to the central level;
- Incomplete reports transmitted, particularly from the regional level; and,
- Missing reports (failure to transmit the number of reports expected).

To resolve these problems, the MDA implementation training will give particular attention to completing the data collection tools. A quality control procedure will be implemented at all levels to assess the MDA data quality and consistency and the M&E activities. Two sessions will be held to validate the MDA data provided by the districts and CSPS. These sessions will help to standardize the data and identify why data differs across levels.

In 2016, the NTDP will conduct post-MDA coverage surveys in four HDs that conduct at least two MDAs during FY16. These evaluations will be conducted within three weeks after the second MDA. The results of these evaluations will help to determine whether reported coverage is in line with actual coverage. Corrective measures will be devised in case any problems are detected. They will be conducted by HKI with support from independent actors with funding from END in Africa.

The integrated NTD database developed by the WHO and RTI/ENVISION and the joint reporting forms will continue to be used in 2016. The 2014 NTD data are already stored there. The plan to deploy the integrated NTD database (IDB) in Burkina Faso includes training in 2015 for the national actors and the regional statistics and epidemiological surveillance managers on using the integrated NTD database. Starting in 2016, the integrated NTD database will thus be used at the national and DRS level.

Lymphatic Filariasis

For LF, certain TAS surveys will incorporate the STH assessments in accordance with RPRG recommendations. In 2016, the application of this recommendation will take effect with combining STH evaluations with TAS 2 in 15 HDs (4 evaluation units) and with TAS 3 in 11 HDs.

Pre-TAS: assessment of night blood microfilaraemia at sentinel/control sites

In accordance with WHO recommendations on the elimination of LF, 21 HDs will undergo pre-TAS surveys, which will be conducted in 42 sentinel/control sites in 2016. Of these 42 sites, 14 (divided among 7 HDs) will receive financial support from the END in Africa project. They are located within the

following health regions: Centre-Est (Tenkodogo HD: 3 sites; Koupela HD: 2 sites; Pouytenga DS: 2 sites); Centre (Bogodogo DS: 3 sites; Boulmiougou HD: 2 sites; Nongr Massom: 1 site; Signoghin: 1 site).

The World Bank project and the government will support the pre-TAS surveys in another 14 sites in 7 HDs. They are located within the following health regions: Est (Fada HD: 3 sites; Gayéri HD: 2 sites; Diapaga HD: 2 sites; Bogandé HD: 2 sites; Manni: 2 sites; Pama: 1site); and Sahel (Sebba: 2 sites). FPSU-L will support pre-TAS surveys in the final 7 HDs, for a total of 14 control sites in the Sud-Ouest and Centre-Sud regions.

The results of these surveys will help to determine whether the HDs in question are eligible to proceed to the TAS to determine whether MDA (IVM+ALB) can be stopped. If they pass, TAS 1 will be conducted in FY17. Otherwise, the treatment will continue and the same survey will be conducted two years later.

Stop MDA Transmission Assessment Survey (TAS I)
If the results of the 2015 pre-TAS are successful, transmission assessment surveys (TAS 1) will be planned in 3 evaluation units (Zabré: region du Centre-Est; Dédougou-Boromo: region de la Boucle du Mouhoun; and Léo-Sapouy: region du Centre-Ouest). The TAS 1 in the Boucle du Mouhoun and Centre-Ouest regions will receive financial support from the END in Africa project. The TAS 1 survey in the HD of Zabré will be supported by FPSU-L.

Post-MDA surveillance surveys (TAS 2 and TAS 3)
In accordance with WHO guidelines, post-MDA surveys are required in the eligible HDs (those that already conducted TAS 1 successfully) to confirm that transmission of LF has been stopped. The surveys are generally conducted at least two years after passing the TAS 1 and then again at least 2 years after the TAS 2.

The TAS 2 will be conducted in 4 evaluation units covering a total of 15 HDs. They are:
- Evaluation unit (EU) of the Centre-Nord region (Kaya-Boussouma, Barsalogho, Boulsa-Tougouri, Kongoussi)
- EU of the Centre-Ouest region (Koudougou-Nanoro-Réo-Tenado-Sabou)
- EU 1 of the Boucle du Mouhoun (Nouna- Solenzo)
- EU 2 of the Boucle du Mouhoun (Toma-Tougan).

Financial and technical support from USAID through the END in Africa project will be solicited for all the TAS 2 evaluations in FY16.

For the TAS 3, 4 EUs, comprised of 11 HDs, will be supported by USAID through the END in Africa project:
- ✓ EU of the Hauts-Bassins region (Orodara-N'dorola)
- ✓ EU 1 of the Nord region (Gourcy-Yako)
- ✓ EU 2 of the Nord region (Ouahigouya-Seguenega-Titao-Thiou)
- ✓ EU of the Cascades region (Banfora-Mangodara-Sindou).

STH evaluations will be coupled with all of the TAS 2 and TAS 3 evaluations with support from END in Africa.

Deleted: Post-MDA passive surveillance ¶

Trachoma

For trachoma, the WHO issued new SOPs in 2015 which revised the criteria for HDs to undergo MDA (this was then operationalized through the revision of eligible HDs for the Zithromax donation through the International Trachoma Initiative). The new SOPs state:

- The elimination criteria for active trachoma is TF<5% among children aged 1-9 years at the district level (this is a change from the previous criteria which stated that elimination was at the sub-district level);
- For districts with a TF prevalence among children 1-9 years between 5-9.9%, programs may choose to provide one round of treatment to be followed by an impact assessment 6 months after the MDA;
- For districts with TF ≥10%, the number of rounds recommended prior to impact assessment depends on: 1) whether the data are baseline or impact data, and 2) the prevalence of TF. The recommended number of rounds for these districts varies between 3 and 7.

Thus, in FY16, trachoma impact evaluations will be comprised of one HD that will finish its third round of treatment (Pô) and followed by impact assessments. The nine others will conduct one round of MDA and conduct impact assessments at least six months later. The NTDP determined that due to the timing of the MDA (March 2016), only a proportion of the 5-9.9% HD (9) could finish impact assessments prior to the end of FY16, since they are supposed to take place at least six months following MDA, which falls in September 2016. The other 13 HD will undergo impact assessment shortly after the beginning of FY17.

END in Africa will support the evaluations in the following 7 HDs: Po (Centre-Sud), Reo, Nanoro, Leo, Tenado (Centre-Ouest), Nongr-massom (Centre) and Houndé (Hauts Bassins). The World Bank will support the impact evaluations in the 3 HDs of Sindou (Cascades), Tougan, and Dédougou (Boucle du Mouhoun). The thirteen other districts receiving MDA in FY16 will undergo impact assessments in FY17. The choice of districts to undergo impact assessment at the end of FY16 vs. the beginning of FY17 was based on the following:

1. Po is finishing its 3rd round of MDA in its second 3-round cycle. Therefore, it is important for the NTDP to have results in case it will need additional rounds in FY17.
2. Houndé was selected as the other districts in this region will undergo impact assessment in November 2016 (in the FY15 workplan/budget, but due to the delay in trachoma MDA in FY16, the impact assessments also needed to be delayed), and completing Hounde's impact assessment will complete assessments (and perhaps confirm elimination) in the whole region.
3. Leo, Reo, Nanoro and Tenado are all in the same region, so this will cut down on travel time and costs if they are all done at the same time and will also complete impact assessments (and perhaps confirm elimination) in the whole region.
4. In keeping with the logic of completing impact assessments by region, Nongr-Massom will be the last HD in the Centre region needing an impact assessment (Signonghin has one planned for November 2016 as part of the FY15 workplan) and perhaps enable that region to meet the active trachoma (TF) elimination criterion for the entire region.
5. Sindou, Dédougou, Tougan are all districts bordering on Mali and will be funded by the World Bank. As the World Bank funding is prioritized to districts bordering either Mali or Niger, these HD fit those criteria.

Onchocerciasis

Community self-monitoring
As part of the implementation of the CDTI activities, CSM will be carried out in FY16. This activity will be funded by END in Africa and Sightsavers, in the Sud-Ouest (4 HDs) (and Cascades regions (2 HDs), respectively.

Post-CDTI coverage surveys
The coverage surveys are conducted after each CDTI campaign so that the program can validate the coverage data reported by the health centers. They will be conducted in the Sud-Ouest and Cascades regions. This activity will be funded by END in Africa and Sightsavers in the Sud-Ouest (4 HDs) and Cascades regions (2 HDs), respectively. Epidemiological and entomological evaluations will be conducted in FY16 in the Cascades region with technical and financial support from Sightsavers and the Centre-Ouest and Est regions with support from the World Bank.

Schistosomiasis
Impact assessment at the sentinel/control sites
In conformity with the recommendations from the SCH program review conducted in 2013 in Ouagadougou, assessments at the SS and CS are planned for 2016. Data collection at sentinel sites will be used to assess the change in the prevalence and parasite density of SCH and STH and to compare them with prior data (2013). Assessments will be conducted in 61 sites (19 SS with USAID funding and 42 CS with World Bank funding).

These sites are distributed as follows:
1. Cascades (1 SS, 1 CS in 2 HDs);
2. Centre-Est (2 SS, 7 CS in 7 HDs);
3. Centre (1 CS in 1 HD);
4. Centre-Sud (1 SS, 2 CS in 3 HDs);
5. Centre-Nord (2 SS, 5 CS in 6 HDs);
6. Centre-Ouest (1 SS, 6 CS in 7 HDs);
7. Est (2 SS, 3 CS in 5 HDs);
8. Hauts Bassins (2 SS, 4 CS in 5 HDs);
9. Sahel (2 SS, 4 CS in 4 HDs);
10. Sud-Ouest (1 SS, 4 CS in 5 HDs);
11. Nord (2 SS, 3 CS in 4 HDs); and,
12. Boucle du Mouhoun (3 SS, 2 CS in 5 HDs).

The choice of these sites is in line with recommendations from the SCH review, which calls for impact assessments in HDs where an MDA includes high-risk adults. All sentinel sites will be funded with USAID support and the control sites with World Bank support. These different evaluation activities will enable the NTDP to update the prevalence data for SCH and STH, as the last SS evaluations were conducted in 2013.

Data Quality Assessment
Burkina Faso has not yet carried out DQA as part of the MDAs. However, the program participated in the WHO December 2014 training on the use of this tool. The training was integrated with the use of the integrated NTD database (IDB). One of the recommendations called for the country to develop a plan to deploy the two tools country-wide. The plan to deploy the NTD IDB and the DQA tool in Burkina Faso

involves the following steps: (i) training for the national actors involved in NTD control efforts; (ii) a workshop to identify the indicators to use for the DQA and the criteria for assessing each indicator; (iii) training for the actors from the regional health directorates in the NTD IDB and the DQA tool; and, (iv) application of the DQA tool during 2017. Deployment is expected to take two years. Technical assistance will be needed to implement the DQA.

M&E Challenges

The main M&E challenge in Burkina Faso is that the NTDP uses population data from the 2006 census, which are extrapolated annually based on the population's growth rate. These updated data are not always consistent with the actual data from the field, which sometimes explains coverage that is too high or below the expected standards. In addition, major migrations in certain areas (in particular, border districts) can make it difficult to obtain accurate population data. Given these problems, the NTDP will monitor coverage in certain areas, including the HDs in the Sud-Ouest, Centre-Est and Centre-Sud regions, through post-MDA coverage surveys and during MDA supervision.

Table 7: Planned Disease-specific Assessments for FY16 by Disease

Disease	No. of endemic districts	No. of districts planned for DSA	Type of assessment	Diagnostic method (Indicator: Mf, ICT, hematuria, etc)
Lymphatic Filariasis	70	21 HDs	Pre-TAS	mf
		5 HDs Zabre, Sapouy, Léo, Dédougou and Boromo (assuming satisfactory results in pre-TAS in 2015)	TAS 1	FTS
		15 HDs Centre-Nord (6 HDs), Boucle de Mouhoun (4 HDs), Centre-Ouest (5 HDs)	TAS 2	ICT
		11 HDs Nord (6 HDs), Cascades (3 HDs), Hauts Bassins (2HDs)	TAS 3	ICT
Soil-Transmitted Helminthes	70	Centre Ouest (Koudougou-Nanoro-Réo-Tenado-Sabou), Boucle du Mouhoun	TAS 2 + STH TAS 3 +STH	Kato Katz

		(Nouna- Solenzo, Toma-Tougan) and Nord (Ouahigouya-Seguenega-Titao-Thiou,Gourcy-Yako)		
Onchocerciasis	6	7 HDs[10] (Banfora, Mangodara, Léo, Sapouy, Pama, Fada, Diapaga)	Epidemiological Evaluation	Skin snip
Trachoma	32	10 HDs Pô Réo, Nanoro, Léo, Tenado, Nongrmassom, Houndé, Sindou, Tougan,Dédougou	Impact Evaluations	Clinical Examination
Schistosomiasis	70	19 HDs Gourcy, Sindou, Bittou, Koupéla, Boussouma, Tougouri Koudougou, Pô, Diapaga, Manni, Dafra, Manga, Dori, Dano, Dédougou, Tougan Solenzo,Boulsa Thiou	Sentinel Site evaluations + STH	Urine filtration, Kato Katz
		42 HDs Mangodara, Nongrmassom, Bittou, Garango, Koupéla, Kaya, Sabou Ouargaye, Pouytenga, Tenkodogo, Zabré, Barsalogho, Boulsa,Tougouri,	Control Site evaluations + STH	Urine filtration, Kato Katz

[10] Banfora and Mangodara are districts with known endemic villages currently under MDA in the Cascades region. Leo, Sapouy, Pama, Fada and Diapaga are all districts where it was known that there were endemic villages; however, prevalence studies had never been carried out, so the actual classification of endemicity was not known. APOC had made the recommendation that villages in these districts (along with some villages in the Centre-Est, Centre-Sud, and the Boucle de Mouhoun) be surveyed to ensure that there is no ongoing transmission. Villages in the Centre-Est, Centre-Sud, and the Boucle de Mouhoun were surveyed in 2014 with support from APOC, so these surveys are to complete the recommendation made by APOC. Please note that Sightsavers will support the surveys in Banfora and Mangodara and that World Bank funds will be used for the surveys in the other districts. USAID funds are not solicited for any of the Oncho surveys in FY16.

		Kongoussi, Léo, Réo, Sapouy, Kombissiri, Tenado,Saponé, Bogandé,Gayéri, Fada, Dandé, Orodara, Léna, Djibo, Gorom, Dori, Ndorola,Sebba, Batié,Diébougou, Ouahigouya,Gaoua, Séguénéga, Nanoro, Titao, Nouna, Toma Kampti		

Planned FOGs to local organizations and/or governments

- Table 8 below has the anticipated number of FOGs, by type of recipient, and proposed activities supported under FOGs.

Table 8: Planned FOG recipients

FOG recipient (split by type of organization)	Number of FOGs	Activities
General Health Directorate	1	▪ Support training sessions for teams from the regions and health districts on MDA campaign implementation ▪ Supply regional health directorates with MDA drugs ▪ Supervise regional and health district teams' implementation of all FY16 MDA campaigns ▪ Collect data at LF sentinel sites ▪ Collect data at schistosomiasis/STH sentinel sites ▪ Conduct trachoma impact studies ▪ Stop MDA TAS 1 for LF ▪ Conduct post-LF MDA surveillance activities (TAS2 et TAS3) ▪ Conduct OV assessments of treatment coverage assessments ▪ CDTI community self-monitoring ▪ Conduct communications activities (IEC/BCC) to encourage strong community participation in NTD elimination activities
Health Regions	12	▪ Provide training sessions for regional, health district and health center teams on MDA campaign implementation ▪ Supervise health district, CSPS and distributor teams on implementation of all FY16 MDA campaigns ▪ Supply health districts and CSPS with MDA drugs ▪ Carry out communications activities (IEC/BCC) to encourage strong community participation in NTD elimination activities

Looking Ahead

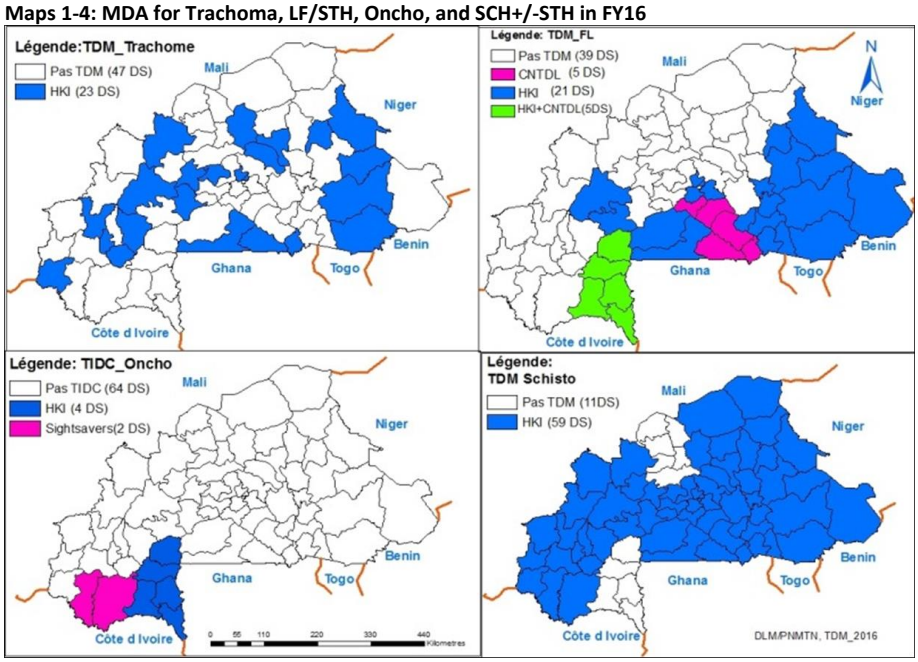
Table 9: Remaining gaps to be addressed

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

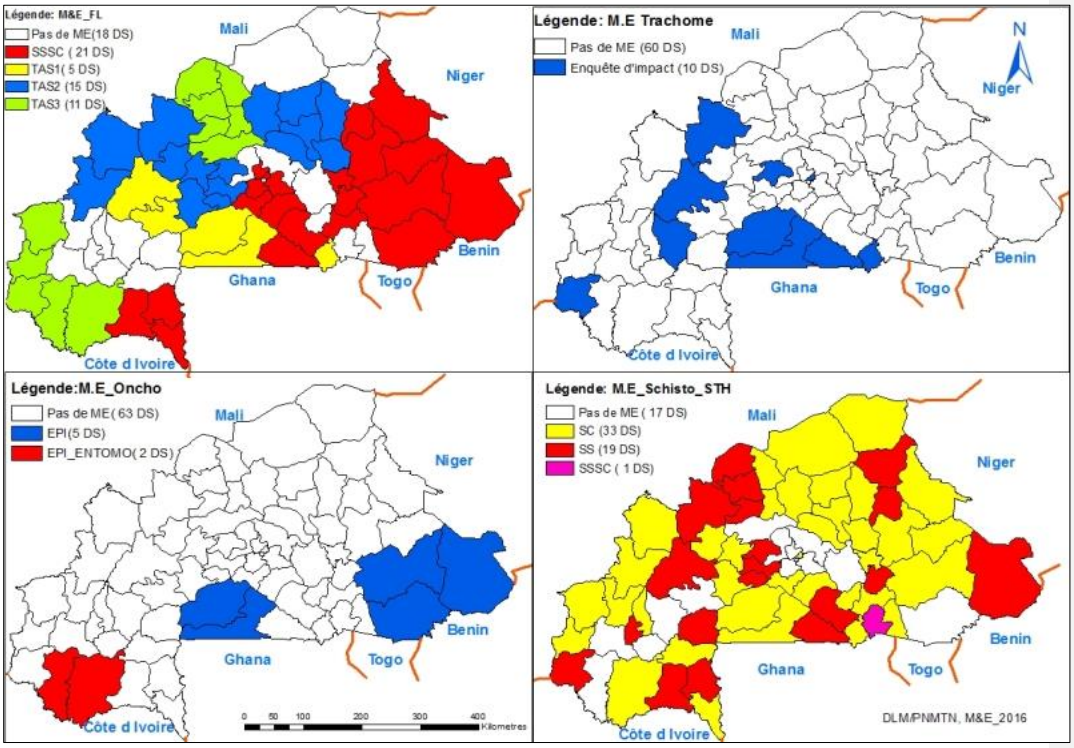
Maps

The maps below show the districts where MDA and DSA will take place in FY16, as well as the endemic status of each district for each of the five PC NTDs.

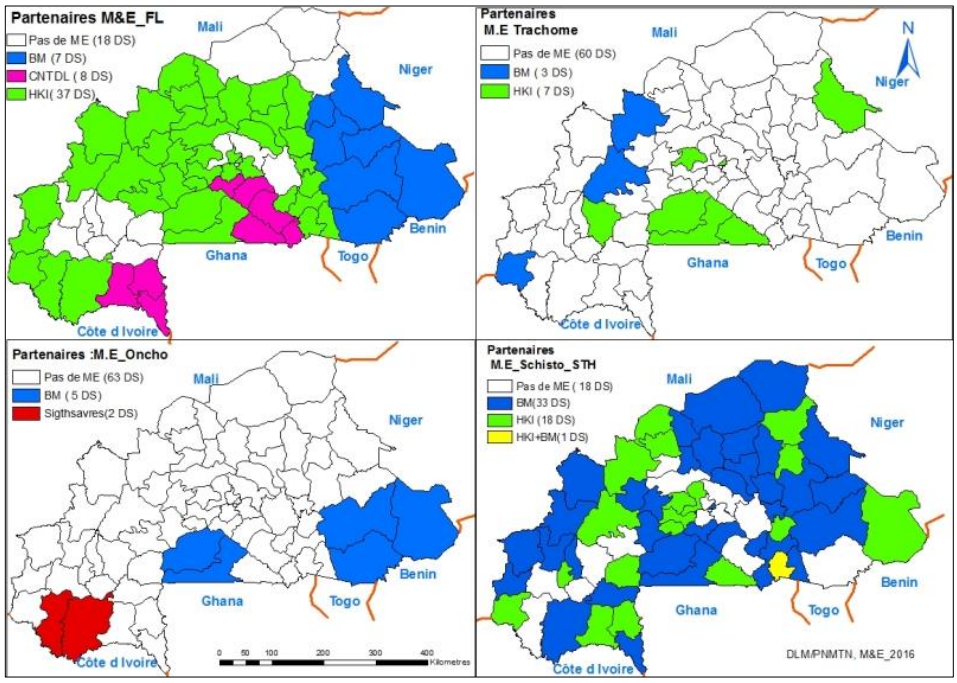
Maps 1-4: MDA for Trachoma, LF/STH, Oncho, and SCH+/-STH in FY16



Maps 5-8: Districts with DSA for LF, Trachoma, Oncho, and SCH/STH in FY16



Maps 9-12: M&E Partners for LF, Trachoma, Oncho, SCH/STH



APPENDICES

1. **Country staffing/partner org chart (replicated from overall work plan) (PDF)**
2. **Work plan timeline (MS Word)**
3. **Work plan deliverables (MS Word)**
4. **Table of USAID-supported provinces/states and districts—refer to this in the narrative instead of listing out all districts/sub-districts (MS Word or MS Excel)**
5. **Program Workbook (MS Excel)**
6. **Disease Workbook (MS Excel)**
7. **Country budget (MS Excel)**
8. **Travel Plans (MS Word or MS Excel)**