BURKINA FASO

FY2017

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)
BCC	Behavior Change Communications
CDC	U.S. Centers for Disease Control and Prevention
CDTI	Community-Directed Treatment with Ivermectin
CMFL	Community Microfilarial Load
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
DLM	Disease Control Directorate (Direction de la Lutte contre la Maladie)
DQA	Data Quality Assessment
DRS	Regional Health Directorate (Direction Régionale de la Santé)
DSA	Disease Specific Assessment
EU	Evaluation Unit
FHI360	Family Health International 360
FOG	Fixed Obligation Grant
FPSU-L	Filarial Programmes Support Unit-Liverpool School of Tropical Medicine
FTS	Filariasis Test Strip
FY	Fiscal Year
HAT	Human African Trypanosomiasis
HKI	Helen Keller International
HD	Health District
ICP	Integrated Communication Plan
IEC	Information, Education, Communication
KAP	Knowledge, Attitude and Practice
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
M&E	Monitoring and Evaluation
MMDP	Morbidity Management and Disability Prevention
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)
NTDP	Programme National de lutte contre les Maladies Tropicales Négligées (National NTD Program)
PSN	National Health Policy (Politique Sanitaire Nationale)
RTI	Research Triangle Institute International
SCH	Schistosomiasis
SCI	Schistosomiasis Control Initiative
SOP	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
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization

COUNTRY OVERVIEW

General background information on country structure

Burkina Faso is a landlocked country of 274,200 km² located in the heart of West Africa. It shares a border with six countries: Mali to the west and north, Niger to the east, and Benin, Togo, Ghana and Côte d'Ivoire to the south. It 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. The country has three main rivers: the Mouhoun, the Nazinon and the Nakambé. As of the 2006 census, the population was 14,017,262[1]. With annual demographic growth estimated at 3.1%, the population is estimated to be 19,632,147[2] in 2017. The average population density is 69 inhabitants/km^2. The official language of this former French colony is French, although over 60 languages are spoken in the country. The main languages are Mooré, Dioula, Fulfudé, Gourmantchéma and Bissa. The main ethnic groups are the Mossi, Bobo, Gurunsi and Fulani.

From an administrative standpoint, Burkina Faso is divided into 13 regions, 45 provinces, 350 departments, 351 communes (of which 49 are urban and 302 are rural) and 8,228 villages. The health system is divided into 13 Regional Health Directorates (DRS) which correspond to the 13 administrative regions. There are 70 health districts (HDs) and 1,698 Health and Social Promotion Centers (CSPS)[3] which are the first line health providers at the community level which act as an interface between the population and the health system.

The Burkina Faso National Health Policy (PSN) is implemented via the intermediary of the National Health Development Plan (PNDS) whose goal is to improve the general health of the population. The current plan covers the period from 2011 to 2020. Neglected Tropical Diseases (NTD) are one of the priorities of this plan. The Burkina Faso Ministry of Health (MOH) implements activities to control NTDs with funds from a number of different sources. The United States Agency for International Development (USAID) has contributed to the fight against NTDs in Burkina Faso since 2007. The MOH receives the funding via 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 provide support for Preventive Chemotherapy (PCT) NTDs in Burkina Faso:

- **The Burkina Faso government** provides support for the implementation of activities to control NTDs, particularly for Mass Drug Administration (MDA) against lymphatic filariasis (LF), LF morbidity management, LF impact assessments and MDAs against Soil-Transmitted Helminths (STH). It provides significant logistical support (vehicles) to carry out and supervise the MDAs and impact assessments. It also provides support for the supply of MDA drugs and other items via exemptions from customs duties and taxes, the payment of fees and customs approvals. The government pays the salaries of NTD program coordination staff in full.

- **Sightsavers** provides financial and technical support for activities to control trachoma morbidity and for the implementation of Community-Directed Treatment by Ivermectin (CDTI), for cross-border meetings, for monitoring and evaluation activities and the elimination of onchocerciasis

[1] General Population and Environment Census, 2006

[2] DGISS demographic projection 2011-2020

[3] Statistical directory, 2015, Ministry of Health

and trachoma in the Cascades region. A support project for trachomatous trichiasis (TT) was implemented in the Nord region in 2016.

- **The Filarial Programmes Support Unit (FPSU) of the Liverpool School of Tropical Medicine (LSTM):** Financial and technical support for the implementation of LF elimination activities: assessment of sentinel sites (SS)/control sites (CS), Transmission Assessment Surveys (TAS), post-MDA monitoring, MDA support and operational research. This support is provided for the Sud-Ouest, Centre-Sud and Centre-Est (Zabré HD) regions. This partner also supports the implementation of activities to manage LF morbidity in the Centre-Est, Centre-Ouest, Centre-Sud and Sud-Ouest regions.

- **FHI 360 via CARE:** in 2016 CARE provided support for the WASHPlus NTD pilot project in the Manni HD. The project was financed by USAID.

- **Institut International d'Ingénierie de l'Eau et de l'Environnement (2iE):** Together with the support of the University of Lausanne, it carries out NTDP research projects in the Centre-Est (Koupéla HD), Nord (Ouahigouya HD) and Hauts-Bassins (Dafra HD) regions as part of activities to control and fight against schistosomiasis. The research is based on a new, integrated approach (environment, socio-hydrology) intended to establish schistosomiasis risk maps in the 13 regions.

- **Health Center Management Committees (COGES):** The committees manage financial resources to support health related activities. Some contribute to the implementation of MDA activities, particularly by providing financial incentives for Community Drug Distributors (CDDs). The financing is not capitalized in all of the HDs and is therefore difficult to evaluate in terms of monetary value.

- **World Bank (WB):** The WB has committed $121 (USD) million to support sub-regional activities to fight against NTDs with a focus on Preventive Chemotherapy (PC NTDs) and the seasonal treatment of malaria in children 3 to 59 months old in Mali, Niger and Burkina Faso from 2015 to 2019. The priority of the multi-year funding is the HDs along the borders of the three countries. The activities carried out in Burkina Faso are: monitoring and evaluation, supervision, support for MDA implementation, case management, research and the improvement of institutional skills and capacities. All of the activities included in this project have been approved.

- **WHO:** Provides technical and financial support and facilitates the acquisition of drugs for the NTDP.

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

Partner	Location (Regions/States)	Activities	Is USAID providing direct financial support to this partner? (Do not include FOG recipients)	List other donors supporting these partners/ activities
2IE	Centre-Est region (Koupéla HD) Nord region (Ouahigouya) Hauts-Bassins region (Dafra)	Support for the implementation of IEC and research activities for the prevention of schistosomiasis	No	None
HKI	13 health regions	Technical and financial support for MDA implementation	Yes	None
		Technical and financial support for monitoring and evaluation (M&E) activities		
		Support to coordinate and provide technical assistance for capacity building		
		Technical and financial support for specific studies		
		Technical and financial support for IEC NTD/Behavioral Change Communications (BCC)		
	Centre-Nord, Hauts-Bassins & Centre-Ouest regions	Morbidity Management and Disability Prevention (MMDP) for LF and trachoma		None
	Est region: Fada district	Trachoma-related activities for the school health project for the F and E components of the SAFE strategy in schools and neighboring communities	No	Yes (Embassy of Taiwan)
FPSU-LSTM	Sud-Ouest, Centre-Sud regions	Technical and financial support to implement and conduct M&E activities	No	Yes (DFID)
		Technical and financial support for LF IEC/BCC activities		
		Technical and financial support for MDA implementation		
		Treatment of LF cases		
		Research		
Sightsavers	Cascades	Technical and financial support for MDA implementation via the CDTI method	No	Yes (DFID)
		Technical and financial support for cross-border meetings and for M&E activities		
		Financial support for NTD coordination		
		Technical and financial support for IEC/BCC activities for onchocerciasis and trachoma		
		Support for trichiasis surgery		
	North	Support for trichiasis surgery		
WB	National, with priority to the 22 HDs bordering Mali and Niger	Technical and financial support for MDA implementation	No	None
		Technical and financial support for M&E activities		
		Support to coordinate and provide technical assistance for capacity building		
		Technical and financial support for specific studies		
		Technical and financial support for NTD IEC/BCC activities		
		Support for morbidity management activities and capacity building		
WHO	13 health regions	Technical and financial support and facilitation of drug purchases for the NTDP	No	None
TFGH	TBD	Operational Research on District Filariases TAS (integrated LF/OV)	Yes	USAID

National NTD Program Overview

A number of vertical programs were implemented between 1991 and 2004 to control the different diseases. The programs had certain shortcomings (e.g. insufficient resources, the withdrawal of technical and financial partners, etc.). The National Onchocerciasis Control Program was established in 1991; the National Program to Eliminate Lymphatic Filariasis was founded in 2001; the National Blindness Prevention Program was included in 2002; and the National Schistosomiasis Control Program was established in 2004.

Given the challenges to be met and the emergence of certain diseases, the inclusion of the programs for specific diseases in the National NTD Program (NTDP) became a necessity. The NTDP was instituted in 2007 and consists of 10 units, each with a unit manager. The 10 units consist of six technical units (trachoma, lymphatic filariasis (LF), onchocerciasis (oncho), schistosomiasis/soil-transmitted helminthes/Guinea worm (SCH/STH/GW), human African trypanosomiasis (HAT) and leprosy/Buruli ulcer/leishmaniasis) and four transversal units (logistics, laboratories, communications (IEC/BCC) and planning/monitoring-assessment). The Disease Control Directorate (DLM), which reports to the General Directorate of Health, is responsible for overseeing the NTD program. A steering committee and a technical committee were created in 2015 to strengthen program management. The NTDP coordinates the integrated activities for the control and elimination of the five NTDs which can be treated with preventive chemotherapy (PC NTDs): lymphatic filariasis (LF), onchocerciasis (oncho), schistosomiasis (SCH), soil-transmitted helminthes (STH) and trachoma. The Regional Health Directorates ensure coordination of the activities implemented by the Health Districts (MDA, CDTI). The distribution of drugs to eligible people is done by health agents and community distributors. Serious adverse events are handled by the district hospitals.

USAID support

USAID support for the NTDP in Burkina Faso began in 2007 via the intermediary of the USAID NTD Control Program to support the implementation of programs against LF, SCH, STH, trachoma and oncho. The project was managed by Research Triangle Institute International (RTI) via the Schistosomiasis Control Initiative (SCI). During this time period, the MOH's vertical programs were combined into a single NTD program (the NTDP). In terms of activities, baseline trachoma mapping was conducted, and the geographical expansion of the MDAs to all endemic districts was completed for the five NTDs targeted. The award also supported M&E activities.

Since 2011, USAID's support for preventive chemotherapy for NTDs has been provided through the END in Africa project managed by FHI360 with HKI as the implementing partner. The project has enabled the NTDP to continue, expand and improve implementation of the activities: MDA for the five NTDs, M&E (e.g. trachoma impact assessments, pre-TAS, and TAS), and capacity building at all levels via training and technical assistance. Technical assistance (TA) has included review of the SCH strategy, review of the LF strategy, logistics management, training on the Tool for Integrated Planning and Costing (TIPAC) and integrated database training.

To-date, 39 HDs of the 70 LF-endemic HDs have reached the criteria to stop MDA. The MDAs for trachoma have stopped in 29 of the 48 endemic HDs. It should be noted that populations were treated for STH during the LF MDA and by adding albendazole (ALB) to SCH treatment campaigns.

A brief overview of the diseases and strategies implemented to achieve the PC NTD control and elimination objectives are described by disease below.

Lymphatic Filariasis

LF was found to be endemic in the 70 HDs based on the mapping completed in 2002. The MOH set an objective for the elimination of LF as a public health problem by 2020 through the following strategies: MDA, treatment of LF morbidity (hydrocele and lymphedema), awareness-raising and BCC, vector control and capacity building. One-hundred percent geographical MDA coverage in endemic HDs was reached in 2005. Transmission Assessment Surveys (TAS) have been carried out in a number of districts and have shown very good results: 39/70 HDs have stopped their annual MDAs. Of the 39 districts that have stopped MDA, 18 have additionally carried out and passed a TAS 2 and six a TAS 3, indicating that transmission has been stopped. In FY16, six HDs will undergo TAS 1 and pre-TAS is planned for 21 HDs (seven with END in Africa, seven with FPSU-L, and seven with World Bank funding). The TAS 1 planned for FY16 are scheduled to take place in August-September 2016. Pre-TAS is has been completed but most results are not yet available. The partial results of the 2016 pre-TAS conducted in seven HDs indicate that the Bogodogo and Tenkodogo HDs have a microfilaria prevalence in excess of 1%. The FY16 MDAs are currently underway in 31 HDs.

There are known persistent pockets of LF in certain regions (Est, Centre-Est, Centre-Sud, Centre-Ouest et Sud-Ouest) where prevalence remains high. Twenty-three districts in these five regions have been administered between 13 and 20 MDA rounds without meeting the criteria to stop their MDA. High population mobility (both inside the country to reach clandestine gold mining sites and to find work, and to neighboring Côte d'Ivoire, which has only recently begun LF MDA) is a significant operational challenge for the efforts to eliminate LF. The implementation of the complementary strategy recommended during the LF review in 2015, notably, ongoing treatment (as opposed to a campaign-based strategy in certain regions), could provide a solution to this problem.

Onchocerciasis

A national program for onchocerciasis was created in 1991 after the shutdown of the former Onchocerciasis Control Program. The current goal of the program is to eliminate oncho by 2025. The main strategies used to achieve this goal have been CDTI, BCC, epidemiological and entomological monitoring, and capacity building.

Six HDs, including two in the Cascades region and four in the Sud-Ouest region are Oncho endemic. CDTI is currently conducted twice a year in the two districts in the Cascades region with Sightsavers support. The four districts in the Sud-Ouest region receive support from the END in Africa project for one round and from FPSU-L for the other. The most recent surveys indicate a considerable decrease in the Community Microfilarial Load (CMFL) in these HDs. The results of the 2010 epidemiological surveys in the Cascades region indicate a prevalence of 71% in the Banfora HD and of 33.9% in the Mangodara HD. Following five years of MDA, an impact assessment to evaluate endemicity is planned for the Cascades region in July 2016 with Sightsavers support.

With respect to the Sud-Ouest health districts, the results of the epidemiological assessment of the four endemic districts in 2011 indicated prevalence between 1.9% in the Diébougou HD and 9.7% in the Batié HD. However, CDTI will be continued to ensure that the 2025 elimination objective is met. Impact assessments are planned for the Sud-Ouest region in 2018.

Schistosomiasis

SCH is endemic in all 70 HDs. The national goal is to reduce prevalence to less than 5%[4] by 2020. The national SCH/STH program was created in 2004 with the financial support of SCI and began to receive USAID support in 2007. The strategy to control SCH includes: MDA, environmental sanitation, BCC, awareness-raising, monitoring and capacity building. An expert review meeting for Burkina Faso and Niger was held in 2012 in Ouagadougou with WHO and international SCH experts. It was recommended that Burkina Faso conduct detailed review of the data and adjust the strategies according to different geographical and epidemiological contexts towards elimination of schistosomiasis in the country. Accordingly, a national SCH program review meeting was held in 2013 to examine prevalence data and the treatment schedule as well as to recommend changes to the treatment plan to help Burkina Faso reach the goals described above. Following the review, a treatment strategy was agreed aligned on WHO guidelines and was implemented in 2015. The treatment plan is implemented by region with treatment annually, biannually or every two years based on prevalence.

Data collection was carried out in 21 sentinel sites in 2016. The partial results, which have not yet been validated by the NTDP, show a promising trend of decreasing prevalence. A total of 62 schistosomiasis sentinel and control sites had been planned for assessment in FY16 (21 SS with USAID funding and 41 CS with financing from the World Bank). However, only the sentinel sites were evaluated, as the World Bank funding was not accessible to cover the costs of the control site surveys.

Biannual treatment in the Centre-Est region appears to be having a significant impact. At the Lioulgou site, prevalence was 56.25% in 2013; the most recent surveys indicate that it is now less than 10%.

Soil-Transmitted Helminths

STH are endemic to all of Burkina Faso's 70 HDs. The national goal is to reduce the prevalence of STH to less than 1% by 2020. The Burkina Faso national SCH/STH program was created in 2004 with the financial support of the SCI and began to receive USAID support in 2007. Control of STH has been integrated with the strategies already in place to eliminate LF and prevent schistosomiasis in Burkina Faso.

The main treatment used since program inception in 2001 has been ALB combined with ivermectin (IVM) during the MDAs for LF. Given the progress achieved in eliminating LF, a combination of ALB with praziquantel (PZQ) during the SCH MDAs in the HDs was adopted as a deworming strategy for populations in those HDs. However, not all districts are treated annually for SCH/STH; 26 districts have stopped MDA for LF and treat for SCH/STH every other year.

Trachoma

The main strategy to eliminate trachoma is the SAFE strategy (Surgery, Antibiotic therapy, Face cleaning, and Environmental change), as well as monitoring and evaluation, BCC and capacity building.

The baseline trachoma mapping carried out between 2007 and 2010 showed that the disease was endemic in 30 HDs (TF prevalence ≥ 10% in children 1 to 9 years old). This led to the implementation of interventions to eliminate trachoma by 2020, including MDA, which was eventually brought to scale. Much progress has been made, and at the end of 2015, 29/30 HDs that had been originally been considered endemic had stopped MDA after having reached the district-level stop MDA threshold of <10% TF during the impact assessments carried out after three consecutive MDA rounds.

[4] NTD Strategic Plan 2016-2020

However, based on the new 2015 WHO standard operating procedures, all HDs with a TF prevalence of between 5% and 9.9% must also be considered endemic and warrant one round of MDA followed by impact assessment six months later. At the end of 2015, 18 HDs had TF prevalence between 5% and 9.9% according to either baseline mapping or the most recent impact assessments and MDA was planned for all these districts in FY16. In addition, the Pô HD will complete its second series of three MDA rounds in the FY16 MDA and will also require an impact assessment before further MDA. The NTDP had originally planned for 10 impact assessments at the end of FY16 and 9 in early FY17; however, due to the late arrival of the Zithromax for the FY16 MDA and the requirement to wait 6 months after MDA to conduct impact assessment, all 19 impact assessments will be conducted in FY17.

Therefore, MDA for trachoma in FY17 is contingent on the results of the FY17 impact assessments. In the event of satisfactory results from the impact assessments (TF prevalence < 5% among children ages 1-9 years), the trachoma MDAs may be stopped countrywide in 2017.

Table 2: Snapshot of the expected status of the NTD program in COUNTRY as of September 30, 2016

		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 09/30/16		No. of districts expected to be in need of MDA at any level: MDA not yet started, or has prematurely stopped as of 09/30/16	Expected No. of districts where criteria for stopping district-level MDA have been met as of 09/30/16	No. of districts requiring DSA as of 09/30/16
					USAID-funded	Others			
Lymphatic Filariasis	70	70	0	0	21	4[1]	0	45[2]	0
Onchocerciasis		6	64	0	4	2[3]	0	0	0
Schistosomiasis		70	0	0	70[4]	0	0	0	0
Soil-Transmitted Helminths		70	0	0	38[5]	4	0	0	0
Trachoma		48	22	0	19	0	0	29	Impact assessment (19) [6]

1. FL MDA: FPSU-LSTM will cover the operational costs of the MDA in the four HDs of the Centre-Sud region. In addition, the Sud-Ouest region receives two MDA rounds per year. FPSU-L provides support for a series of MDAs in the five HDs of the Sud-Ouest and END in Africa provides support for the other series.
2. Of these 45 HD, six will undergo a TAS 1 at the end of FY2016 and we expect that the results will lead a stop of the MDA by the end of FY16.
3. These 26 districts have DSA for LF planned in FY17: 4 HD for pre-TAS; 15 for TAS 1 and 7 for TAS 3
4. CDTI for Oncho in two HDs in the Cascades region with financial support from Sightsavers.
5. The NTPD has planned to conduct epidemiological and entomological surveys in 5 HD in FY17.
6. All of the HDs are currently being treated either twice a year, once a year or every two years. All receive MDA support from END in Africa.
7. The NTDP has planned sentinel site surveys in 28 sites in 16 HD for FY17.
8. The HDs are treated for STH via LF or SCH. However, where the LF MDA has been stopped, and given that the HDs don't all treat for SCH annually, some HDs are not treated for STH every year.
9. The NTDP has planned TAS 1 + STH and TAS 3+ STH in 22 HD in FY17.
10. 19 districts required MDA in FY16 and all 19 required impact assessments following the MDA. 10/19 of the districts were planned to undergo impact assessment in FY16, and the others had been planned for FY17, as the NTDP did not believe it would be able to do all surveys in the final months of FY16. However, given the fact that the FY16 Zithromax was delivered late (late May 2016) and given the minimum six-month period required between MDAs, the following will not able to conduct impact assessments in FY16 as planned: Dédougou, Tougan, Sindou, Nongre-Massom, Léo, Nanoro, Réo, Tenado, Pô and Houndé. Therefore, all 19 HDs will have an impact assessment in FY17

PLANNED ACTIVITIES

NTD program Capacity Strengthening

Burkina Faso has a National Health Policy document and a National Health Development Plan which include NTD control. A 2016-2020 strategic plan to control NTDs is currently being developed to follow up on the 2012-2016 plan. The documents are used for advocacy to mobilize resources for NTD control. However, it must be acknowledged that the internal capacity to mobilize funds for NTDs remains weak given the financial difficulties experienced by the country.

Technical assistance is planned for FY17to strengthen resource mobilization capacities and develop long-term financing mechanisms for activities to control NTDs. In addition, the national steering committee for NTD control is responsible for advocacy to mobilize resources for the prevention of NTDs. It is also responsible for monitoring implementation of the guidelines and evaluating program performance.

In addition, the following activities planned for FY17 also contain training components to strengthen the capacity of the National Program at all levels to carry out activities:

- MDA cascade training will provide an opportunity to strengthen the knowledge of NTDs (causes, consequences, prevention) by all actors;
- Regional level data managers will learn how to use the integrated database;
- Personnel will be trained to conduct a number of different epidemiological surveys: pre-TAS, TAS 1, TAS 3+STH integrated surveys, and trachoma impact surveys;
- Head nurses will be trained in CDTI for OV

In addition, END in Africa will provide support for external experts to participate in and advise the technical committee, which is responsible for establishing the major strategic directions for the joint implementation of activities and for formulating technical decisions for the NTDP, based on national and international recommendations for the control and prevention of NTDs in Burkina Faso.

Project Assistance

The following activities are planned for FY17. They will be implemented with funding based on the FOGs.

Strategic Planning

- Quarterly coordination meetings
- Annual planning workshop
- Development of a trachoma elimination plan for the period 2017-2020
- SCH/STH transition planning workshop
- NTD steering committee meetings

Advocacy

- Field visit for MDA campaign launch with high-level authorities within the Ministry of Health
  Information sessions at central, regional and district levels with political, religious and traditional authorities prior to MDAs

Social Mobilization

- Communication and social mobilization activities at all levels of the health system (radio and TV spots, village-level criers, etc.)

Capacity Building / Training

- Training of trainers, supervisors and CDDs taking part in implementing the MDA activities to control NTDs at all levels of the health system.
- Training of regional-level data managers on integrated NTD database
- Training of field staff for TAS 1, TAS 3, and trachoma surveys
- Training of head nurses on CDTI

MDA

- MDA for SCH in 28 HDs (all with END in Africa support)
- MDA for LF in 25 HDs (of which four HDs in the Centre-Sud region receive financial support from FPSU-L and four HDs in the Sud-Ouest region receive END in Africa support for the first round and FPSU-L funding for the second round)
- MDA for Oncho in six HDs (including two HDs with Sightsavers financial support)
- MDA for trachoma in 10 HDs (all financed by END in Africa and subject to the results of the impact assessments planned for early 2017)
- MDA for STH included in the FL and SCH MDAs in 42 HDs (of which 25 HDs are included in the LF MDA and 17 included in the SCH MDA). All are funded by the END in Africa project, except for the four districts in the Centre-Sud region, which are supported through FPSU-L

Drug and Commodity Supply Management and Procurement

- Supply of drugs, data collection tools, and IEC materials for MDA implementation at all levels
- Purchase of tetracycline eye ointment for trachoma MDA (if required)

Supervision

- Supervision of the personnel involved at all levels during MDA campaign implementation
- Updating of CDTI village registers

Monitoring & Evaluation

- Collection of NTD campaign MDA data at all levels
- Post-MDA review meetings at the district and regional levels
- National level meeting to validate the MDA data
- Pre-TAS in four HDs (3 will be supported by END in Africa and 1 with FPSU-L support)
- TAS 1 in 15 HDs (11 with END in Africa support and 4 with FPSU-L support)
- TAS 3 in 7 HDs (all with END in Africa support)
- Integrated STH + TAS 1+ in 15 HDs (all with END in Africa support)
- Integrated STH + TAS 3 in seven HDs (all with END in Africa support)
- Trachoma impact assessments in 19 HDs (15 with END in Africa support; 4 with WB support)
- Oncho therapeutic coverage surveys and community self-monitoring
- Biannual integrated database updates

The following work plan does not include specific projects for gender equality or greater involvement by women. However, during the MDA, many messages are addressed specifically to women, either because they suffer greater exposure to the disease (trachoma) or because they are primarily responsible for the

children and are the main population at risk for the other diseases (SCH and STH). The program also plans to give priority to women in the selection of trainers, supervisors and CDDs.

Strategic Planning (Location in Budget: ODC (Planning budget tab, lines 163-167)

Total cost for activities in this section: $40,007

The FY17 NTDP activities are selected based on the needs of the program and depend on the prevalence of the disease and the results of the impact assessments (if required) at the end of the FY16 implementation period and on WHO recommendations. It also should be noted that the NTDP experienced major difficulties updating the TIPAC in 2014 and 2015 and decided to suspend its use in FY16 while waiting for a definitive solution and has no plans to use TIPAC in FY17.

In addition, it should be noted that updates to the FY17 operational plan may be required following development of the 2016-2020 strategic plan for the NTD program, which is currently underway, and the STH review planned for 2016.

A plan to eliminate trachoma during the 2017-2020 period will be developed in 2017. It will take into account the new trachoma elimination guidelines issued by WHO in 2016. USAID financial and technical support via the END in Africa project is being requested for the workshop (also see Short-Term Technical Assistance section).

The NTDP is also planning to hold an SCH/STH transition planning workshop to discuss how MDA for these diseases can continue once USAID support to this activity ceases. Discussions will include other platforms that can be used as well as identifying financial and technical partners. Participants will include current stakeholders, Ministry of Health personnel and representatives from programs / organizations that may be potential platforms for MDA delivery. Support is requested from the END in Africa project.

In FY17, quarterly coordination meetings between the NTDP and partners are planned to ensure smooth implementation of activities. USAID support is requested to support these meetings: two meetings through the END in Africa project; the other two meetings will be held with support from the MMDP project.

As per usual, an FY18 work plan development workshop will be held in May-June 2017, followed by a meeting with partners to approve the plan.

Finally, a technical committee and a steering committee were set up in 2015. Among other things, the committees are responsible for setting the major directions for the joint implementation of activities and for formulating technical opinions about NTDP coordination proposals based on national and international recommendations for the control and prevention of NTDs in Burkina Faso. In FY17, END in Africa support will be needed to support 1 technical committee meeting and 2 steering committee meetings. With the exception of the onchocerciasis subcommittee, the other subcommittees were not able to hold statutory meetings in 2016. The meeting of the subcommittee for the elimination of onchocerciasis approved the impact assessment protocol for the endemic districts in the Cascades region. The other subcommittees expect to begin their activities in FY17. The World Bank will provide financial support to the sub-committee meetings. In order to reinforce the technical competence of the technical committee, the NTDP is also soliciting assistance for technical expertise during the quarterly technical committee meetings and a budget line is included for travel for an external expert.

NTD Secretariat (Location in Budget: ODC (Planning budget tab, lines 169-170))

Total cost for activities in this section: $17,248

Burkina Faso NTD Coordination requests operational support from the END in Africa project in FY17 for:

- Two portable computers for NTD coordination to handle the needs associated with new NTDP staff, notably in the M&E unit
- Four computers for the Est, Sud-Ouest, Centre-Sud and Centre-Est regions, given the installation of the integrated NTD database in the regions to improve NTD data management, facilitate data quality evaluations and ensure correct archiving and data security, particularly in regions with high NTD prevalence. These regions have aging computer equipment and often lose data and, therefore, need new computers
- Six external drives to back-up data; 2 for the NTDP and 4 for the Est, Sud-Ouest, Centre-Sud and Centre-Est regions
- Financial support for communications and Internet access
- Office supplies and consumables including paper, binders, ink and other consumables required for printing
- One complete desktop computer for the BDIM at the national level. This is a recommendation from the integrated database training, which was held in February 2016 in order to ensure that data are secured and managed in one place.
- One printer: the NTDP's printers have broken down and a new printer is necessary for the NTDP to conduct daily business.

Advocacy for Building a Sustainable National NTD Program (Location in Budget: FOGs, planning tab line 132)

Total cost for activities in this section: $38,376

Burkina Faso is subdivided into communes, each of which is a local authority with a legal and financial autonomy. In addition, the transfer of certain areas of responsibility to the communes, including health, provides opportunities to promote support for health activities, particularly for NTD control.

In addition to this political and administrative organization, there are local NGOs and private companies able to provide support for the actions to control NTDs. Advocacy will be carried out with elected officials, private companies and NGOs and other organizations which can potentially provide support for raising resources for the prevention of NTDs.

Burkina Faso previously experimented with having the programs mobilize resources in 2004. The experience enabled it to create a line in the government's budget for the fight against LF. The budget line is currently being used for all NTDs and advocacy is ongoing to increase it. However, it should be noted that there are some obstacles for the NTDP engaging in resource mobilization:

- Current administrative procedures do not enable the NTDP to take the lead in mobilizing resources from private companies. That is, national policies do not permit individual programs to mobilize resources, as this is the purview of the Ministry of Economy and Finance. Therefore, the NTDP needs to advocate with other organizations to assume leadership for raising funds on its behalf. The NTDP can be involved in providing technical assistance to these organizations in the development of fundraising strategies but cannot directly engage in fundraising activities itself.
- The lack of financial resources to implement a resource mobilization strategy

- The lack of a financial resources mobilization committee
- The unstable socioeconomic environment in private companies.

Therefore, the NTDP proposes:

- Advocacy with existing NGOs to obtain buy-in to carry out resource mobilization activities on behalf of the NTDP
- Advocacy with NGOs to implement a resource mobilization committee
- Once a committee is set up, train committee members on resource mobilization and management.

Measuring success
Advocacy efforts will be measured using the following indicators:

- The number of NGOs committed to carrying out resource mobilization activities for the program
- The existence of a resource mobilization committee. These are community –based advocacy groups whose primary role is to build strong relationship with potential donors to gather resources for the community. However, due to lack of financial support, this committee is not yet up to speed.
- The existence of a startup fund for resource mobilization activities for the NTDP
- The number of companies actually approached by advocacy activities for resource mobilization
- The number of organizations actually providing funding will be compared to the number of organizations that have pledged.
- The resources mobilized through advocacy.

The schedule for implementing a resource mobilization strategy in the country is as follows:

- Hold discussions with the MOH to explain the resource mobilization process, planned for the first quarter of 2017
- Advocacy with existing NGOs to obtain their buy-in to carry out the resource mobilization activities, planned for the first quarter of 2017
- Advocacy for the implementation of a resource mobilization committee, planned for the second quarter of 2017
- Train the committee members on resource mobilization, planned for the second quarter of 2017
- Discussions between the NTDP and the government about NTDP activities post-transition from USAID financial support to funding by the government, planned for the fourth quarter 2017.

It should be noted that no funds are required to put this strategy into place at this time.

MDA advocacy
At the central level, officials from the central directorate, as well as the WHO and partners of the NTDP will travel to the field for the MDA launch. This field visit will be widely covered by the media, which helps the NTDP to:

- Ensure visibility of the campaigns
- Inform the public of the importance of the NTD control efforts
- Ensure that the representatives from high levels within the Ministry of Health as well as regional and local representatives are mobilized during the campaign to advocate for participation

- Reassure the populations of the efficacy and safety of the medicines used during the campaigns
- Encourage the CDDs during their work to distribute the medications

The site chosen for the field visit for the MDA launch will be either a site where prevalence remains high despite numerous rounds of MDA or where evaluations indicate that MDA needs to continue. It also could be a site where coverage has been low.

Regional level
An advocacy day will be organized with the administrative, traditional and religious leaders of all MDAs in all regions before the start of the first MDA in each region to ensure buy-in for activities to prevent NTDs. The main messages that will be conveyed include the current epidemiological status of the NTDs in the region, the undesirable side effects of the drugs, previous results, the difficulties experienced during the MDAs, the expectations of the regional health management team. In all, 12 advocacy days will be organized in the administrative centers of the health regions in which MDAs will be conducted in 2017.

Health district level
A one-day advocacy, information and awareness-raising meeting with the political, administrative, traditional and religious leaders in a given district will be held during each MDA. The main messages that will be conveyed include the current epidemiological status of the NTDs in the region, the undesirable side effects of the drugs, previous results, the difficulties experienced during the MDAs, the expectations of the district health management team.

Social Mobilization to Enable NTD Program Activities (Location in Budget: FOGs, Planning budget tab, lines 134-135)

Total cost for activities in this section: $86,898

The NTDP developed an integrated communication plan (ICP) for the 2012-2016 period to ensure full buy-in of NTD prevention activities by the population. However, ICP implementation was not completed due to a lack of financial resources. Nevertheless, MDA implementation-related activities are planned and implemented every year. Communication activities are also carried out during the disease evaluations to ensure population compliance.

A review of the ICP is planned for 2016. It will include an analysis of stakeholders in terms of IEC implementation for NTD control and of the IEC materials themselves. This activity will be financed by the World Bank project.

In order to ensure that local populations are committed to participating in MDA, social mobilization activities are carried out at the various levels of MDA campaign implementation. There are five levels: central, regional, health district, health center, and community. The activities are planned for implementation before and during the campaigns.

The central level implements activities which receive media coverage from national channels. The messages are addressed to the entire population of all endemic areas. This ensures that the population realizes that the project is being carried out in other areas as well. The regional level uses regional media and targets the population of the region taking into account its specificities (the population's knowledge, attitudes and practices (KAP), difficulties encountered in previous MDAs, etc.). The health district level uses community radio stations and creates messages based on the specificities of the people living in that

district (the population's KAP, the problems encountered during MDAs, etc.). The health center level carries out activities which specifically involve villages within their health catchment area. The community level carries out local awareness-raising actions.

As in previous years, the NTDP will utilize printed materials, such as posters and printed handouts during the MDA and during the different evaluations. However, in FY17, all printed materials will be paid for with World Bank funds.

Planned Social Mobilization Activities

The activities planned by each level for MDA implementation funded by USAID are as follows:

MDA Social Mobilization

1. Central Level

- Broadcast audiovisual media in French and three national languages to support MDA campaign implementation (these are the same materials created in FY16). The program plans to create TV and radio ads for this level. The ads will be broadcast to assist staff during the MDAs. The main messages will inform the population about the campaign period, the disease for which the MDA is being carried out and the areas in question and will ask residents to participate. The END in Africa project is requested to fund broadcasting of the ads in 2017. The broadcasts will reinforce those financed by other partners in order to increase the awareness created during previous MDA campaigns. The following number of broadcasts are planned:
    - For the LF MDA: 20 TV and 60 radio broadcasts in French and three national languages
    - For the SCH MDA: 20 TV and 60 radio broadcasts in French and three national languages
    - For the trachoma MDA: 20 TV and 60 radio broadcasts in French and three national languages.

- The NTDP will broadcast movies about LF to raise awareness about that disease. The content of the movies will include the manifestations, transmission methods and socioeconomic impact of NTDs. The program plans to:
    - Broadcast two movies about LF twice on the national channel.

- Create a 15-minute radio micro-program in three languages on LF, Oncho, SCH and trachoma. The micro-program messages will provide information about the diseases, transmission methods, and prevention measures, which include the MDA campaigns. The program will:
    - Broadcast each micro-program four times during each MDA campaign (16 times total)

2. Regional Level

- Create a 30-minute radio program in French for each MDA in the region. The program will discuss the disease addressed by the MDA, transmission methods, the drugs used, and the campaign process.

- Create one-minute ads: one in French and three in the three most-spoken languages in the region about the NTDs covered by the MDA.

3. Health District Level

- Broadcast a program in local language in the HD during each MDA.

- Radio message content: the message will also cover identification of the disease, the transmission method, prevention measures and the drugs used for the campaign.
- Given the low education level of local residents, the messages will be created in the most widely spoken local languages
- Target: the community

- The one-minute ads created by the regional level for each MDA in the district's most-spoken languages will be broadcast 20 times.

- Broadcast the 30-minute radio program created by the DRS in French one time for each MDA.

- Show videos on LF and Oncho in two villages with poor coverage in each of the 25 HDs that will be treated for LF and the six HDs that will be treated for Oncho.
  - Message: as indicated above, the films will cover the disease, its manifestations, prevention measures and its socioeconomic impact
  - Targets: the communities of areas in which coverage by previous campaigns was weakest.

4. Health Center Level

- Inform and raise the awareness of the political, traditional, religious and administrative authorities during each MDA.
  - Head nurses will travel to meet with authorities, school principals and other organizations in the area to provide information and raise awareness. The goal is to gain their support for MDA implementation, notably that of teachers for the treatment of children in the schools. Note that while this activity occurs annually, a budget is not needed to conduct it.

5. Community Level

- Inform and raise the awareness of local populations via town criers.
- Inform and raise the awareness of local populations via relays and community distributors during distribution.
  - A town crier will circulate in each village to provide information before and during the MDA
  - During distribution, the CDDs will use brochures to continue to raise the awareness of people receiving the drugs and, particularly, of those who are reticent.

Disease Assessment Social Mobilization

Social mobilization activities planned for the disease assessments include:

- Broadcast radio and TV messages to inform the population of TAS implementation and of the diseases that will be monitored. The messages will be broadcast via the regional media and community radio stations of the health districts in question. Information broadcast on the television doesn't always reach the village level, but relatives in towns who have been informed by TV or radio contribute to reassuring their relatives in the villages about the legitimacy of the activity.

- Provide media coverage during the pre-survey with the program managers, the surveyors and the local authorities to reassure the communities.

- Community awareness-raising with guides who also act as relays between the surveyors and the community during the surveys. The guides can also translate in the event of a language barrier.

Social mobilization effectiveness

No specific actions have been carried out to assess the implementation of communication activities. However, the LF coverage surveys carried out in the regions as needed are always paired with a KAP survey which enables verification of the effectiveness of communication activities. For example, in 2015 and 2016, the surveys provided insight into the population's knowledge of NTDs in the Sud-Ouest region. They enabled the teams of this region to improve certain aspects of communication intended for the communities (notably about disease vectors, which the population isn't always aware of).

In addition to pairing KAP surveys with coverage surveys, the NTDP is also planning to review the ICP. The review will be preceded by an assessment of the current status of behavioral change communications (BCC). This activity will be carried out with WB funding.

The results of these assessments will be used to set goals and redirect strategies and activities for the prevention of NTDs.

Evaluation methodology

The methods used to assess the success of awareness-raising among the population include:

- NTD KAP surveys combined with treatment coverage surveys. The surveys contain questions which help to determine how most people obtain information about the MDAs and if social mobilization influenced their decision to take part in them. The suggestions received during the surveys help to improve communication about future campaigns.
    - The results of the 2015 KAP survey coupled with the TAS in the Sud-Ouest region showed that the main sources of information about the MDA campaigns were the town criers (31.50% and the radio 15.40%), followed by health care staff (6.1%) and television (4.8%).

- An independent assessment of oncho CDTI coverage carried out in 2015 in the Banfora and Mangodara health districts revealed that among people who were eligible for treatment but didn't take IVM during the last treatment campaign, 2.9% stated that they didn't take the IVM because the CDDs didn't come to their home; 24.3% were absent (away for work or on a trip) when the CDDs visited; 4.3% were not aware treatment was under way; and 8.6% simply refused treatment.

- Community self-monitoring (CSM) carried out after the CDTI helps to assess what the population knows about the disease and the level of participation in actions to eliminate oncho. The process involves the community monitoring the progress of the CDTI via community meetings and by requesting feedback about the way in which the CDTI was carried out and what can be improved.
    - Specific IEC/BCC data collection tools will be developed in addition to combining the KAP surveys with the coverage surveys and CSM. They will be used to monitor activities during the MDA and to document positive points and the tools which need to be improved.

Table 3: Social Mobilization/Communication Activities and Materials Checklist for NTD work planning

Category	Key Messages	Target Population	IEC Strategy (materials, medium, activity etc.)	Where/when will they be distributed	Frequency	Is there an indicator/ mechanism to track this material/activity? If yes, what?	Other Comments
MDA	Identification of the disease; manifestations, transmission method, prevention measures, treatment	Communities Advocacy targets (administrative, traditional and religious authorities)	Flyers and posters	The flyers and posters are available three weeks prior to the start of the MDA	Once per year	Number of flyers and posters provided to the regions Percentage of health centers using the posters and flyers during the campaign Therapeutic coverage during the campaign	Financed by the WB
	Endemicity of NTDs in Burkina, impact of NTDs on development, Importance of NTDs/need for engagement by everyone	Communities Advocacy targets (administrative, traditional and religious authorities)	MDA Launch	1st day of 1st MDA campaign	Once per year	The number of launches held Number of persons taking part in the launch Therapeutic coverage during the campaign	Financed by END in Africa
	Disease definitions, presentations, modes of transmission and	Administrative, traditional and religious authorities	Advocacy with authorities at the regional district and	Before the start of the first MDA at the regional level and before the beginning of each MDA at the	Once at the regional level and 1-4 times at the district and	Number of advocacy session held	Financed by END in Africa

Category	Key Messages	Target Population	IEC Strategy (materials, medium, activity etc.)	Where/when will they be distributed	Frequency	Is there an indicator/ mechanism to track this material/activity? If yes, what?	Other Comments
	prevention, treatment; impact on development; importance of NTDs/need for engagement by everyone		community level	district and community levels	community levels	Rate of participation in the advocacy meeting Therapeutic coverage	
	Disease definitions, presentations, modes of transmission and prevention, treatment; impact on development; importance of NTDs/need for engagement by everyone	Communities with poor coverage	Projection of films	During the campaign	Once per year	the number of times shown Therapeutic coverage during the campaign	Financed by END in Africa
	Identification of the disease, manifestations, transmission method, prevention measures, treatment	Communities	Radio and TV ads and programs	Ads during six days starting two days before the MDA	Depending on the number of MDAs (each district may have 0-3 MDAs)	Number of radio ads and programs created Percentage of persons treated who received information about the MDA via the radio or TV	Financed by END in Africa

Category	Key Messages	Target Population	IEC Strategy (materials, medium, activity etc.)	Where/when will they be distributed	Frequency	Is there an indicator/ mechanism to track this material/activity? If yes, what?	Other Comments
	Identification of the disease, manifestations, transmission method, prevention measures, treatment	Communities	Town criers	Town criers for six days starting one day before the campaign	Depending on the number of MDAs (each district may have 0-3 MDAs)	Number of town criers used Percentage of persons treated who received information by public criers	Financed by END in Africa
	Identification of the disease, manifestations, transmission method, prevention measures, treatment	Communities	Movies broadcast on the national channel	During the campaign	Two movies once per year	Number of movies shown on the national channel Percentage of the population with knowledge about NTDs	Financed by END in Africa
	Identification of the disease, manifestations, transmission method, prevention measures, treatment	Communities	Radio and TV programs on national channels	Three micro-programs broadcast during the three MDAs	12 times/year	Number of micro-programs created and broadcast Percentage of the population with new knowledge about NTDs	Financed by END in Africa
Assessments (TAS, trachoma impact surveys, coverage surveys)	manifestations, transmission method, prevention measures, treatment	Community	Posters	For the duration of the survey	Depends on the number of assessments	Number of posters provided for the surveys Percentage of health centers using the poster during the MDA	Financed by the WB

Category	Key Messages	Target Population	IEC Strategy (materials, medium, activity etc.)	Where/when will they be distributed	Frequency	Is there an indicator/ mechanism to track this material/activity? If yes, what?	Other Comments
	Identification of the disease, manifestations, transmission method, prevention measures, treatment	Community	Guides	During the survey	Depends on the number of clusters	Number of guides used Percentage of persons surveyed	Financed by END in Africa
	Identification of the disease, manifestations, transmission method, prevention measures, treatment	Community	Pre-survey media coverage	At the start of the practical phase of the survey	Depending on the number of evaluation units (EU)	Media coverage provided by the EU Percentage of persons surveyed in the EU	Financed by END in Africa
	Identification of the disease, manifestations, transmission method, prevention measures, treatment	Community	Radio and TV messages	Before and during the survey	Depends on the number of surveys	Number of radio messages	Financed by END in Africa

Training (Location in Budget: FOGs, Planning budget tab lines 137-140)

Total cost for activities in this section: $252,772

Capacity building/Training (Location in the budget: FOG)

Several capacity building and training sessions are required for the FY17 MDA. They include:

- **National level:** A training session for **56** trainers on campaign implementation will be held for the staff of the 12 health regions implementing the MDAs and for NTDP staff. The training topics will include MDA monitoring and supervision, drug management and implementation guidelines, the management of side effects, community mobilization and data collection and management.

- **Regional level: Training/refresher courses will be** held for **169** regional and HD staff on MDA campaign implementation. The training topics will include MDA monitoring and supervision, CSM and implementation guidelines, the management of side effects, community mobilization and data collection.

- **District level: Training/refresher courses** will be held for **1,260**head nurses on MDA campaign implementation. The training topics will include MDA monitoring and supervision, AMC and implementation guidelines, the management of side effects, community mobilization and data collection.
    - In the Sud-Ouest region, 108 head nurses in 4 HD will be re-trained on CDTI for oncho. These persons will be trained before each of the two rounds. These nurses are trained once during the LF MDA and a second time specifically on CDTI for oncho.

- **Health center level: training/refresher courses will be provided as follows:**
    - A training/retraining for 36,155 CDDs for the planned MDA campaigns:
        - LF: 16,386 CDDs, including 900 urban distributors (UD).
            - END in Africa will provide funding for 13,870 CDDs, of which 756 will be UDs.
            - The other 2,516 CDDs, of which 144 are Urban Distributors, will receive support from FPSU;
        - SCH: 11,355 persons total: 3,024 health agents for the first round and 756 health agents for the second round; 5,957 CDDs for the first round and 1,618 CDDs for the second round. All will be funded by funded by END in Africa.
        - Trachoma: 4,606 persons total; of which 1,080 are health agents and 3,526 are CDDs, all with END in Africa funds;
        - Oncho: 3,808 CDDs will be trained total; 3,210 with support of END in Africa and 598 with Sightsavers' support.

The MDA training sessions will cover standard operating procedures for administering medications (usage of dose poles, directly observed therapy, etc.), reporting, the management of side effects, and community mobilization. For oncho, this CSM and updating of village registers and census cards (oncho only).

In addition, a training will be held for regional-level NTD and M&E staff on the integrated NTD database. The purpose of this training is so that the regions understand what data are required by the central level and can ensure correct reporting.

Table 4: Training Targets

Training groups	Training topics	Number of attendees			Number of training days	Training location	Other funding partner (if applicable, e.g. MS, SCI)
		New	Refresher	Total			
Integrated training for central level trainers carrying out a MDA	MDA/CDTI implementation; MDA/CDTI monitoring and supervision; SCM and SOP for MDA/CDTI drugs; management of side effects; Social mobilization	0	56	56	2	Ouaga	None
Integrated training of DRS and HD level trainers carrying out a MDA		0	169	169	2	Regions	None
Integrated training for head nurses on carrying out MDAs	MDA guidelines; Filling out data collection tools	0	1,260	1,260	2	Districts	None
Training for head nurses on carrying out CDTI	MDA guidelines; Filling out data collection tools	0	108	108	2	Regions	None
LF training for DCs and health agents	Training on dose pole use; drug administration; identification of side effects; social mobilization; writing of MDA data collection tools	0	16,386	16,386	2	Health center	FPSU-L (2516)
SCH training for DCs and health agents		0	11,355	11,355	2	Health center	None
Trachoma training for DCs and health agents		0	4,606	4,606	2	Health center	None
Oncho training for DCs and health agents		0	3,808	3,808	2	Health center	Sightsavers (598)
NTD and M&E staff	Utilization of the integrated NTD database	30	0	30	5	Regions	None
TAS 1 surveyor training*	Survey methodology and organization, practice, and conducting a household census	97	0	97	1	Regions with TAS 1	None
TAS 3 surveyor training*	Survey methodology and organization, practice, and conducting a household census	54	0	54	1	Regions with TAS 3	None
Trachoma impact assessment surveyor training*	Survey methodology and organization, practice, and conducting a household census	21	0	21	3	Ouaga	None

*Described in M&E section of the workplan

Mapping (Not budgeted)

Total cost for activities in this section: $0

A mapping of SCH, LF, trachoma and onchocerciasis has already been done at national scale.

MDA Coverage and Challenges (Location in Budget: FOGs, Planning budget tab line 143)

Total cost for activities in this section: $317,318

MDA (Location in the budget: FOG)

The FY17 MDAs will be conducted in 12 health regions (67 HDs). Each MDA will cover 100% of the HDs targeted. The number of HDs targeted per NTD is as follows:

- LF = 25; (subject to the results of the FY16 TAS 1 in 6 HD); 17 with only END in Africa support, 4 co-supported by END in Africa and FPSU-L (each partner supports 1 round), and 4 districts funded by FPSU-L only
- SCH = 28
- STH = 42 (38 with END in Africa support and 4 with FPSU-L support)
- Trachoma = 10 (subject to the results of the impact assessments, scheduled for Q2 FY17)
- Oncho=6; 2 districts funded by Sightsavers

In addition to USAID via the END in Africa project, the main MDA partners are:

- **Sightsavers:** Provides implementation support for CDTI against Oncho in two HDs of the Cascades region
- **FPSU-L:** Provides technical and financial support for the LF MDA in the Sud-Ouest region (4 HDs) and Centre-Sud region (4 HDs).
- **World Bank:** Provides financial support for the implementation of activities to control NTDs (in addition to funding for MDA training, financial compensation for the CDDs and communication and monitoring activities) in the districts undergoing MDA with priority support for the districts along the border with Niger and Mali.

The distribution strategies for the target populations for each drug package are as follows

IVM + ALB distribution: MDAs will be carried out in 17 HD with funding from the END in Africa project only; 4 districts will receive support uniquely from FPSU-L; and 4 HD will receive two rounds of MDA, one round through END in Africa support and one round through FPSU-L support. Since 2009, four HDs in the Sud-Ouest region (Batié, Dano, Diébougou, and Gaoua) have been carrying out biannual MDAs for LF due to the persistently high prevalence of microfilariae (≥1%). The total target population is 4,424,098 for all partners; the target for districts supported by END in Africa is 3,744,946.

Community distribution is done annually by community volunteers (community health agents or other persons in the community). Two distributors carry out distribution at each site for at least six days. This period can be extended if the planned coverage is not reached. Pills are given to the population using door-to-door methods, in villages, sectors, health centers, barracks, schools, field-to-field and in farming hamlets. Treatment will be provided to the residents of gold-mining sites and at other gathering points. Awareness-raising sessions will be carried out to improve treatment coverage. Health agents will ensure distribution to urban populations to reduce the number of refusals.

PZQ tablet distribution: The mass treatment strategy for SCH is based on WHO standards and the recommendations of the program review of November 2013 in Ouagadougou. Therefore, in hyper-endemic areas (prevalence in excess of 50%), seven HDs receive two MDAs annually; 10 HDs receive one treatment annually; and 53 HDs receive a treatment every other year. Twenty-eight HDs are targeted for the 2017 MDA, that is, a total of 5,908,486 (4,646,352 for the first round and 1,262,134 for the second round). All of the districts conducting an MDA against SCH in FY17 will do so with END in Africa funding. The distribution methods used will be door-to-door, field-to-field, in the communities, barracks, places of worship, markets, schools and farming hamlets.

Health agents will distribute the tablets in the villages/sectors. These agents generally do not live in the communities they are treating and are therefore accompanied by community volunteers or community health agents who live in the areas targeted for treatment. The latter act as guides and awareness raisers and help to reach the largest possible number of people targeted for treatment. As a result of the many side effects reported at the beginning of the program, it was decided to assign health professionals to PZQ distribution in order to have greater assurance that minor and major side effects would be diagnosed quickly and managed correctly. This will also ensure better acceptance of the MDA by the population.

Azithromycin + tetracycline eye ointment 1% (TEO) distribution:
An estimated ten HD with an estimated target population of 2,749,937 people may require MDA for trachoma in FY17, subject to the results of the impact assessments in all 19 HDs still under treatment in FY16; the impact assessments are planned to take place in Q1-Q2 FY17[5]. End in Africa funding is being requested for implementation of the MDA, if and where required.

Due to budget restrictions, the supply of tetracycline eye ointment previously acquired from the government budget was suspended in 2014. As a result, the 2015 MDA was carried out without the drug. However, END in Africa assisted the NTDP with the purchase of tetracycline eye ointment 1% for the trachoma MDAs in FY2016. It appears that it will again be necessary for END in Africa to provide funding to the NTDP for the acquisition of tetracycline ointment for the FY17 MDAs, should any district require MDA.

The drugs (azithromycin + TEO 1%) will be distributed by health agents in every village/sector. The distribution methods used will be door-to-door, field-to-field, in the communities, barracks, places of worship, markets, schools and farming hamlets.

The 1,080 health agents who will distribute the drugs do not generally live in the communities in which they will be distributing the drug. They will be accompanied by 3,526 community agents who live in the communities targeted for treatment. The latter act as guides and awareness raisers and help to reach the largest possible number of people targeted for treatment.

Distribution of IVM for Onchocerciasis in the Cascades and of IVM+ALB for LF and Oncho in the Sud-Ouest region:
Six HDs currently require CDTI for Oncho in oncho-endemic communities. Distribution takes place twice a year in all six HDs of two regions (Cascades and Sud-Ouest) using the CDTI strategy. The END in Africa

[5]Burkina Faso determined that because 18/19 districts have TF prevalence between 5-9.9% among children ages 1-9 years that it would be unlikely that all districts would require treatment in FY17; they therefore made an educated guess on the exact districts that might require MDA. This is why we have used the wording "estimated" to describe the number of districts and targeted population for trachoma MDA. The number of districts that require MDA may change and the specific districts selected in the Workbooks to undergo MDA may also change.

project supports the Sud-Ouest region and Sightsavers supports the Cascades region. The target is 160,498 persons in each of the two rounds in the Sud-Ouest region.

The distribution strategy used is door-to-door to the households in endemic villages and farming hamlets. Each CDD has an Oncho treatment register containing the identities of all community members in the CDDs' community; CDDs then mark which community members participated in the MDA.

CSM will be used in FY17 in all six HDs in order to improve treatment coverage and enable the communities in question to buy into treatment implementation (END in Africa will support CSM in the Sud-Ouest region only).

Distribution of IVM+ALB or PZQ+ALB for STH: All 70 HDs are STH endemic and are treated either via the LF MDA (IVM+ALB) or via the SCH MDA (PZQ+ALB). In FY17, 42 HDs will receive MDA, 38 with the financial support of the END in Africa project and four with funding from FPSU-L (Centre-Sud region (Kombissiri, Manga, Pô and Saponé districts)). In all, 3,581,807 people are targeted for all partners (SCH MDA=1,510,928; LF MDA=2,070,879).

Table 5: USAID supported coverage results for FY15/16 ** and targets for FY17

NTD	# Rounds of annual distribution	Treatment target (FY15/16)[1] # DISTRICTS	# Districts not meeting epi coverage target in FY15/16*	# Districts not meeting program coverage target in FY15/16*	Treatment targets (FY15/16) # PERSONS	# persons treated (FY15/16)	% of treatment target met (FY15/16) PERSONS	FY17 treatment targets # DISTRICTS	FY17 treatment targets # PERSONS
LF	once a year	27	0	0	4,579,535	4,641,284	101.34%	17	3,744,946
	twice a year	4	0	0	639,633	0	0	4[2]	471,741
OV	twice a year	6	0	0	142,324	153,689	107.98%	4	160,498[3]
SCH	once a year	52	0	0	4,562,097	4,186,609	91.76%	21	4,646,352
	twice a year	7	0	0	1,246,443	1,143,677	91.75%	7	1,262,134
STH	once a year	64	0	0	4,947,360	2,447,134	49.46%[4]	38	3,336,244
TRA	once a year	19	0	0	1,199, 646	1,157,426	96.48%	10[5]	2,749, 937

[1]All data are from the FY15 MDA as FY16 MDA data are not yet available.
[2]4 districts are targeted for twice yearly MDA for LF. One round is supported through the END in Africa project and the second through FPSU-L.
[3]160,498 persons are targeted per round of MDA for a total of 320,996 treatments for oncho.
[4]The low coverage for STH in FY15 is mainly due to the fact that the SCH MDA was conducted without ALB in a number of districts.
[5]The number of districts and targeted population for trachoma MDA are estimates only, as all districts will undergo impact assessment at the beginning of FY17.

Drug and Commodity Supply Management and Procurement (Location in Budget: FOGs, Planning budget tab line 145; ODC, line 177)

Total cost for activities in this section: $57,965

The logistics and pharmaceutical supply unit of NTDP coordination is responsible for managing drugs and the other related supplies for the prevention NTDs. The program has a logistics procedures manual which is used as the reference document for drug logistics management.

The main drug management difficulties reported in 2016 were:

- The late arrival of drugs which prevented implementation of the MDAs according to the initial schedule (particularly PZQ, TEO, and Zithromax). The budget constraints affecting the country again made it impossible to purchase TEO through government resources. A late request was made to END in Africa for its acquisition, and the supplier did not have enough drug in stock. In addition, there were continued worldwide drug shortages, particularly of Zithromax, which contributed to the delay of the trachoma MDA. However, the trachoma MDA was finally able to start in July 2016.

- Insufficient storage space at the central level given the quantities received.

- Non-funding of a request to conduct post-MDA logistics audit by the World Bank.

Quantification of drugs takes place on an annual basis and is the responsibility of NTD program coordination. The logistics forecasts for the program are based on:

- The NTDP's annual goals
- The number of target persons to be treated
- Consumption/distribution data from prior MDAs
- The inventory available for use at the country level
- The delivery period.

Quantification ranges from the district level to the regional level with final consolidation at the national level.

Joint requests

The WHO's joint drug request and reporting form is used for the program and are submitted six to eight months before product delivery. This form is used to request the IVM and ALB. However, despite the fact that the NTDP is using this form, those responsible for filling it out experience difficulties due to the fact that they haven't been fully trained on how to fill it in.

Transportation and storage in the country

The program receives funding from USAID for drug transportation from the central level to the regional directorates for all PC NTDs and from the regions to the HDs. Drug transportation and delivery is done using secure trucks and qualified personnel at the distribution sites. The steps are as follows:

- Validation of inventory data for remaining stocks from previous MDAs
- Drug and input distribution plans
- Development of the terms of reference for the MDA required as part of the FOG milestones to release funds to carry out the MDA, distribution reports and requests in line with FOG contents
- The regions are supplied by NTD program coordination
- The HDs are supplied via the regional pharmacies
- The health centers are supplied via the district pharmaceutical departments
- The distributors are supplied by the Head Nurses.

With respect to storage, the personnel responsible for NTD product logistics management were trained according to the guidelines for proper health product storage. The guidelines apply to district, regional and central level warehouses. The main guidelines are:

- Avoid pushing products up against walls or putting them on the ground
- Avoid exposing the drugs to sun or heat

- Protect the drugs against extreme temperatures during transport by truck
- Protect the drugs from water and rain
- Find a temporary storage area near the MDA location
- Store the drugs in secure, locked and guarded warehouses.

Generally speaking, the country has low storage capacity[6] (only 25% of health facilities have sufficient storage capacity).

Reverse logistics
Management of the program's drug inventories is based on a procedures manual which clearly defines the inventory management tools and roles and responsibilities of all players. Drug management is based on lots and on the principle of "first expired, first out." Each health structure must do a physical inventory of remaining stocks at the end of each campaign and forward them to the next highest echelon. The stocks of peripheral health centers are sent to the health district administrative centers and the stocks remaining in the districts are sent to the regional level where the post-MDA logistics audit takes place. The reverse logistics process is documented with return slips that ensure reverse logistics traceability. A logistics dashboard for remaining stocks is created at the national level. It is managed by the logistics manager who provides follow-up and ensures that they are taken into account in the next donations.

The waste created by the MDAs is generally handled according to national guidelines and the procedures contained in the program's logistics procedures manual. The management of waste and expired products is included in the post-MDA logistics audit.

Supervision (Location in Budget: FOGs, Planning budget tab lines 147-148)
Total cost for activities in this section: $240,796

Supervision occurs at all levels in the health system for all NTD activities (MDA, M&E). Each health system entity (central, regional, district, health center) receives funds in accordance with the budget line approved in the FOG allocation. The resources include per diem for supervising health professionals and fuel for travel. Depending on the recommendations from the MDA assessment meetings, rental vehicles will be provided at the central level to ensure that staff can travel to the field to supervise the MDAs. In addition, the technical and financial partners will take part in supervising staff during the MDA campaigns. The primary objective of the supervisory visits is to guarantee the quality of campaign organization and implementation. The information is collected based on the MDA guides and supervision audit lists developed. The assessment meetings which follow each MDA provide an opportunity to discuss performances and shortcomings and to formulate recommendations to improve the next MDAs.

The following planned activities will help to identify and solve any issues related to MDA implementation:

- Supervision will help to assess the performance of the players involved in implementing the MDAs and to resolve the problems identified at all levels
- Periodic data monitoring during MDA implementation will help to identify any bottlenecks and to take corrective measures
- A status meeting during the campaign will provide an opportunity to take decisions about corrective measures

[6] John Snow, Inc. technical assistance report for the country from April 16 to May 8, 2015.

- The results of previous supervisory activities and the lessons learned will help to anticipate solutions to the problems encountered during the campaigns.

The following actions are planned for data collection to ensure that it is collected and recorded in line with established protocols and procedures:

- Data collection tools will be provided in accordance with national procedures and WHO protocols at all levels
- Cascade supervision from the central level to the health center level will help ensure that the implementation guidelines and the data collection tool instructions for use are available and implemented at all levels during the MDA
- The instructions for data collection tools use will be presented at the MDA training sessions planned for all personnel involved at the different levels (regions, HDs, health centers and community)
- The support of NTDP coordination teams at the training sessions will help to ensure that the training content complies with NTDP guidelines
- The involvement of the END in Africa project teams in training sessions and monitoring activities will provide an opportunity to underscore data collection requirements with partners filling in the M&E reporting workbooks required by the donor
- An update followed by reproduction of the CDTI village registers is planned in the region of the Sud-Ouest; support through END in Africa is requested for this activity.

Annual data manager monitoring will be carried out at the regional level as part of NTD data management. It will provide an understanding of the use of the integrated NTD database following the training planned in FY17 (see training table above) and an opportunity for NTD data management capacity building for the players involved.

Short-Term Technical Assistance (Location in Budget: Travel, Planning budget tab, lines 84 & 100)

Total cost for activities in this section: $8,223

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	Funding source (e.g., country budget, overall budget, CDC funding)
Internal support (e.g., RTI/HQ, USAID, CDC)				
Develop a trachoma elimination program	Provide the NTD program with a road map to reach the trachoma elimination projections by 2020.	Trachoma expertise (e.g. ITI, HKI, NTDP)	8 days Second quarter	Country budget
Support to technical committee/elimination commitees (e.g. oncho)	Technical expertise in NTDs and experience in elimination committees to assist the NTDP in making sound technical decisions to reach elimination	NTD expertise	Twice per year	END in Africa

The NTDP plans to develop an elimination plan to guide their efforts over the next few years to reach the elimination targets for both TF (TF<5% among children ages 1-9 years) and TT (<1 unknown case per thousand population) and to ensure that the NTDP can respond to all criteria outlined in the dossier template released by the WHO in April 2016. The NTDP is approaching the International Trachoma Initiative to provide a trachoma expert consultant to provide the technical assistance.

The NTDP has also expressed a need for technical assistance during its technical committee meetings and oncho elimination committee meetings. They have asked END in Africa for support for two trips by NTD experts to attend these meetings over the course of FY17.

Monitoring & Evaluation (Location in Budget: FOGs, Planning budget tab lines 151-158; ODC, Planning budget tab lines 183-193)

Total cost for activities in this section: $418,882

M&E, Data Quality and Integrated Database

An annual review of post-MDA data will be carried out with the data managers of the health regions. This will enable validation of the MDA data provided by the districts and the health centers and will help to harmonize the data and identify the reasons for potential discrepancies. MDA data validation will also be included in the assessment meetings at the health district level.

The integrated NTD database developed by WHO and RTI/ENVISION and the associated report forms will be used in FY17. Central level staff received database training in FY16. The NTDP has a national MDA database for the 2011-2015 period which is updated on a regular basis and feeds into the WHO Joint Reporting Form and the integrated database. An NTD data collection template implemented in 2016 provided a large quantity of historical data which can be stored in the integrated database. The database has been partially updated and contains NTD data from 2014 and 2015. Semi-annual workshops will be held to update the integrated database; END in Africa funding is requested for these workshops. The sessions will provide consolidated and consistent data to meet all of the information needs of partners. It was not possible to start using the integrated database at the regional level in 2016. Training of regional level data managers is a prerequisite and will be provided in FY2017 with END in Africa support. Post-training monitoring will also be provided in 2017 to gauge the level of use of the integrated database at the regional level.

No changes are planned to the M&E strategy based on activities from FY16. However, to note, advocacy is underway for the training and implementation of passive surveillance in districts which passed the TAS 3.

Lymphatic Filariasis

The NTDP follows WHO guidelines and RPRG recommendations for LF M&E activities. The following activities are planned for LF in FY17:

Pre-TAS: assessment of nocturnal microfilaremia in sentinel and control sites

In line with WHO guidelines for the elimination of LF, pre-TAS surveys will be conducted in 4 HDs in 15 sites in 2 regions, (2 sentinel and 13 control) in FY17. The two sentinel sites are in the Ouargaye districts and control sites will be selected in the Ouargaye, Koupela and Bittou districts. The NTDP has selected an elevated number of control districts because all of these districts have had 13 rounds of MDA and the prevalence in Bittou and Ouargaye were 2.2% and 3.5%, respectively, during the last evaluation in 2015, and the NTDP wants to ensure that they have representative prevalence data on which to base future decisions.

Of the 15 sites, 12 (in 3 health districts in the Centre-Est region) will receive financial support from the END in Africa project (Ouargaye: six sites, Koupéla: three sites, Bittou three sites). FPSU-L will provide support for the pre-TAS surveys in the Diébougou HD in the Sud-Ouest region (3 additional sites). The results of the pre-TAS surveys will determine if the HDs are eligible for a TAS 1 in FY18.

Transmission Assessment Survey (TAS 1) for MDA suspension
If the results of the 2016 pre-TAS are satisfactory, TAS 1 will be carried out in eight evaluation units (15 HDs), 6 of which are planned under END in Africa support and 2 under FPSU-L. In order to carry out TAS 1, a training will be carried out (see Training table) for 97 persons.

1. Boulmiougou -Nongre-Massom-Signoghin: All have been continuing treatment in the rural areas only after failing TAS 1 in 2012. The FY16 pre-TAS survey showed that all the rural parts of these districts will undergo TAS 1 in FY17(rural part) (END in Africa)
2. Pouytenga - Garango (END in Africa)
3. Manga-Pô (FPSU-L)
4. Kombissiri-Saponé (FPSU-L)
5. Bogandé-Manni (END in Africa)
6. Diapaga (END in Africa)
7. Gayéri-Pama (END in Africa)
8. Sebba (END in Africa)

Post-MDA monitoring surveys (TAS 3)
In accordance with WHO guidelines, post-MDA surveillance surveys are required in the HDs which passed TAS 1 or TAS 2 to confirm the continued interruption of LF transmission and to take any measures required.

A TAS 3 will be carried out in three evaluation units covering seven HDs, all with END in Africa support. They are:

1. Plateau Central (Boussé – Ziniaré - Zorgho)
2. Sahel (Dori, Gorom-Gorom, Djibo)
3. Centre (urban areas of the Centre districts; of these, the entire Baskuy district will be included, as it is completely urban, unlike the other districts, which have peri-urban and rural areas.)

Prior to the TAS 3 field work, a training will be carried out for 54 persons (see Training table above).

Passive monitoring post-MDA suspension
In 2016, biomedical technicians in four regions (Centre-Ouest, Centre-Nord, Plateau central and Sahel) received training on passive monitoring. However, the activities have still not begun due to a lack of financial resources for the acquisition of inputs and the follow-up meetings. Advocacy will be carried with the WB in 2017 to ensure start-up of the activity and its future extension to other regions that have achieved a successful TAS 3.

STH + TAS
STH assessments will be included in the TAS 1 in all 8 planned evaluation units (15 HDs) and with the TAS 3 in the three planned evaluation units (7 HDs). Financial support is being requested from USAID via the END in Africa project for all the STH assessments.

Schistosomiasis

SCH and STH impact assessments at sentinel/control sites

According to the WHO protocol and the recommendations of the SCH program review carried out in 2013 in Ouagadougou, assessments in sentinel sites (SS) and control sites (SC) are planned for FY17. In line with the recommendations of the review, the regions targeted for increased MDA frequency (two times a year or once a year) will undergo a SS assessment once every two years. Moreover, the zones with a predominance of *S. mansoni* should also be evaluated annually. In 2016 the impact evaluation in the region of Est showed a high prevalence in the Nagbingou site of 23.75% and the NTDP proposes to conduct annual evaluations.

The data collected from the SS will enable measurement of the impact of the increased MDA frequency initiated in 2014. Assessment of the control sites will enable confirmation or invalidation of the prevalence at sentinel sites for implementation of the disease elimination strategy. Sentinel site assessments will be conducted in 18 sites in FY2017 (6 HDs: Bittou, Koupela, Diapaga Manni, Dafra and Dori). Control site assessments will be conducted in 10 sites in 10 HD (Mangodara, Sindou, Garango, Ouargaye, Zabré, Léo, Tenado, Djibo, Gorom-Gorom and Sebba). All surveys will be conducted with support from the World Bank.

Trachoma

The WHO issued new Standard Operating Procedures (SOP) for trachoma in 2015, which revised the MDA eligibility criteria, and districts with TF between 5-9.9% became eligible for treatment. Based on the new SOP, 19 districts (of which 18 with prevalence between 5 and 9.9% from baseline mapping or impact assessments) planned to conduct MDA for trachoma in 2016. The impact assessments for all 19 districts are planned for early FY17. However, to note, 10 of these impact assessments had been planned for FY16, with the remaining 9 to conduct impact assessments in early FY17. However, because of the late arrival of the drugs in FY16 and consequent delayed MDA, all impact assessments need to be delayed until FY17 so that they can take place at least 6 months following the distribution which began in July 2016.

END in Africa will provide support for the impact assessments in the following 15 HD: Pô, Réo, Nanoro, Leo, Tenado, Nongre-Massom, Houndé, Zabré, Boussouma, Kaya, Kongoussi, Fada, Gayéri, Manni and Pama. The WB will provide funding for the impact assessments in four HDs: Sindou, Tougan, Dédougou and Sebba.

As part of the trachoma elimination validation process, the new trachoma SOP also require surveillance surveys two years following impact assessments where TF<5%. The NTDP has planned to conduct 11 surveillance surveys in four regions. They are: Saponé, Kombissiri, Manga, Titao, Bogandé, Koupéla, Pouytenga, Bittou, Garango, Ouargaye and Tenkodogo. Financing for the surveys in these 11 districts, will be funded through the World Bank.

Onchocerciasis

Community self-monitoring

CSM will be conducted in FY17 as part of CDTI implementation activities. END in Africa funding will be requested to carry out the activity in the Sud-Ouest region. Financial assistance has been requested from Sightsavers to carry out the activity in the Cascades region (two HDs).

Post-CDTI coverage survey

Post-CDTI coverage surveys will be carried out after each campaign to enable the NTDP to validate the coverage data reported by the health centers. They will be conducted in the health regions of the Sud-Ouest and Cascades regions. END in Africa financial support is being requested for implementation of the activity in the Sud-Ouest region (four HDs) and that of Sightsavers in the Cascades region (two HDs).

Epidemiological and entomological assessments
Epidemiological and entomological assessments will be conducted in FY17 in the Centre-Sud (Pô HD), Centre-Est (Tenkodogo HD, Zabré HD) and Est (Diapaga HD, Pama HD) regions with financial support from the WB.

Data Quality Assessments
DQA implementation is planned in two regions during calendar 2016 with WB financing. DQA results will enable the implementation of corrective actions to improve the quality of both data and the reporting system. Two regions with trained staff will be selected to evaluate the quality of post-MDA data with the assistance of NTDP and HKI staff.

M&E challenges

The main M&E challenges are:

- One major NTDP challenge is the persistent high prevalence of certain NTDs (LF, SCH) despite multiple MDA rounds. To meet the challenge, the NTDP is contemplating implementation of ongoing IVM treatment in certain regions (Sud-Ouest, Est and Centre-Est) for people returning from neighboring countries (Ghana, Cote d'Ivoire) to better handle the population movements between the countries. Other solutions will include further supervised administration of drugs during the MDAs and the implementation of CDTIs in certain districts.
- The use of integrated data collection tools and support for DQAs are also challenges for the NTDP. Further training of agents in the use of the BDIM and the implementation of the DQA in all regions is planned to help manage this issue (see training section above).
- The shortage of retro information on NTDs means that NTD issues are not taken into consideration in health activities at all levels, as health personnel are not sufficiently informed about NTDs and they are considered just a once per year campaign, as opposed to a full integrated program with year-round activities. The following actions should be carried out to remedy this situation:
    - Participation in meetings/conferences
    - Publications of program data
    - Publications of program activities and data in Ministry health bulletins on a semi-annual basis. Information and retro information bulletins every half-year for the various players and capacity building for the coordination team and the DRS
- Obtaining accurate population data is a continuous constraint for the NTDP, as for all Ministry of Health interventions.

Table 7: Reporting of DSA supported with USAID funds that did not meet critical cutoff thresholds*

NTD	Number of endemic districts	Type of DSA carried out (add extra rows as needed for each type)[1]	Number of DSAs conducted with USAID support	Number of EU that did not meet critical cutoff thresholds
Lymphatic Filariasis	70 (with 25 continuing MDA FY16)	Pre-TAS	10 SS (7 HD)	0
		TAS1	0	0
		TAS 2	7 HD (3 EU)	0
		TAS 3	6 HD (2 EU)[2]	0
Onchocerciasis	6	Epidemiological evaluation	0	N/A
		Entomological evaluation	0	N/A
Trachoma	48 (with 19 continuing MDA FY16)	Impact Assessment	4 HD	0
		Revaluation of Prevalence	4 HD	3[3]
Schistosomiasis	70	SS	0	N/A
		CS	0	N/A
Soil-transmitted helminths	70	SS	0	N/A

[1]Data are from FY15, as the data from the FY16 DSAs have not yet been validated.
[2]The Government of Burkina Faso paid for the field costs in 1 EU (3 HD) and END in Africa covered the field costs for the other EU (3 HD). The END in Africa project covered the costs of all ICT cards for both EUs.
[3]The NTDP re-evaluated the prevalence of TF in 4 districts that had not received the SAFE strategy to determine whether intervention would be needed (all of these districts had had a baseline prevalence between 5-9.9%). The results indicated that 3 of 4 districts still had a prevalence between 5-9.9% and these districts all were planned for MDA in FY16.

Table 8: Planned Disease-specific Assessments for FY17 by Disease—list for all implementers in the states/regions/areas where END in Africa is working, and note those supported with USAID funds. It is not necessary to list for the entire country. If the numbers don't match the workbooks, please explain why.

Disease	No. of endemic districts	No. of districts planned for DSA	Type of assessment	Diagnostic method (Indicator: Mf, ICT, hematuria, etc.)
Lymphatic Filariasis	70 (with 25 continuing MDA)	4 HD (2 SS+ 10 CS); 3 HD (12 sites) sites with END in Africa support; 1 HD (3 sites) with world Bank support	Pre-TAS	Mf
		15 (11 HD with END in Africa support and 4 with FPSU-L support)	TAS 1	FTS
		7 HD (all with END in Africa support)	TAS 3	FTS

Disease	No. of endemic districts	No. of districts planned for DSA	Type of assessment	Diagnostic method (Indicator: Mf, ICT, hematuria, etc.)
Schistosomiasis	70	6 HD for SS (18 sites); 10 HD CS (10 sites); all with World Bank support	Sentinel site / control site	Kato-katz kit
Soil-transmitted helminths	70	15 (all with END in Africa support)	STH+TAS 1	Kato-katz kit
		7 all with END in Africa support)	STH+TAS 3	Kato-katz kit
Onchocerciasis	06	5	Epidemiological survey	OV-16, skin snip
		5	Entomological survey	Fly capture
Trachoma	48 (with 90 continuing MDA)	30	19 impact assessments (15 with END in Africa support and 4 with WB support); 11 surveillance surveys (World Bank support)	Clinical examination

Planned FOGs to local organizations and/or governments

Table 9: Planned FOG recipients—include for all subpartners as well.

FOG recipient (split by type of recipient)	No. of FOGs	Activities	Target Date to USAID
General Directorate of Health	*1*	• *MDA launch (central-level advocacy)* • *Central level social mobilization (radio/TV spots for LF, SCH, trachoma; microprograms on LF, oncho, SCH and trachoma)* • *Training of trainers for MDA* • *Central level data managers' training on the NTD integrated database* • *Drug logistics (trachoma, SCH, LF)* • *Central-level MDA supervision (trachoma, SCH, LF, oncho)* • *Supervision of the regional and HD teams implementing the FY17 MDA campaigns* • *Pre-TAS* • *Trachoma impact assessments* • *Oncho coverage survey* • *Oncho community self-monitoring* • *TAS 1* • *TAS 3*	*Oct 2016*

		• *STH evaluations coupled with TAS 1 and 3* • *Post-MDA review meetings; post-oncho MDA meetings*	
DRS	*12*	• *Information sessions at regional and district levels with authorities (trachoma, oncho, LF, SCH MDA)* • *Regional and district-level community mobilization (radio spots, radio programs, public criers, projection of films prior to LF, oncho, SCH, and trachoma MDA)* • *Integrated training of MDA supervisors (regional health district levels)* • *CDD/health worker MDA training (LF, oncho, SCH, and trachoma MDA)* • *Oncho printing of materials* • *MDA distribution (costs for CDDs and health workers to distribute drugs) for LF, oncho, SCH, and trachoma MDAs* • *Drug logistics (districts to health centers) for SCH, trachoma, and LF* • *Supervision at the regional, district and health center level (trachoma, SCH, LF and oncho MDAs)* • *Post-MDA and post-oncho review meetings at regional level*	*Oct 2016*

Cross-Portfolio Requests for Support

END in Africa and ENVISION projects should use this section to identify and describe any areas in which other USAID-funded NTD project support might be needed

MMDP: Highlight any country requests for support for LF and/or trachoma MMDP-related activities. Examples may include assessing the burden of LF and/or trachoma morbidity, assistance to develop national MMDP plans of action or trachoma action plans, piloting new tools such as the LF MMDP toolkit and/or new trachoma morbidity tools, etc.

Research: Highlight any country requests for support to address technical or programmatic barriers to achieving elimination and control goals in country that may require research support or investment.

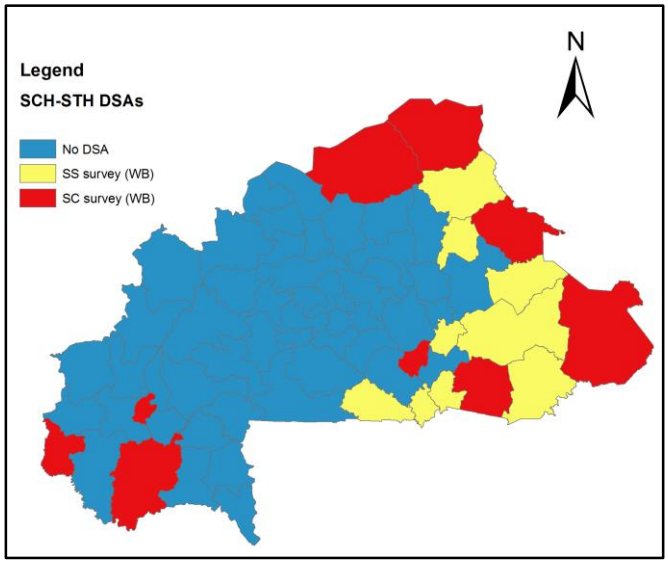
Please note: USAID will consider activities listed in this section and prioritize them against support needs and resources across the NTD portfolio. USAID also intends to share these requests with other partners that may be interested in providing support.

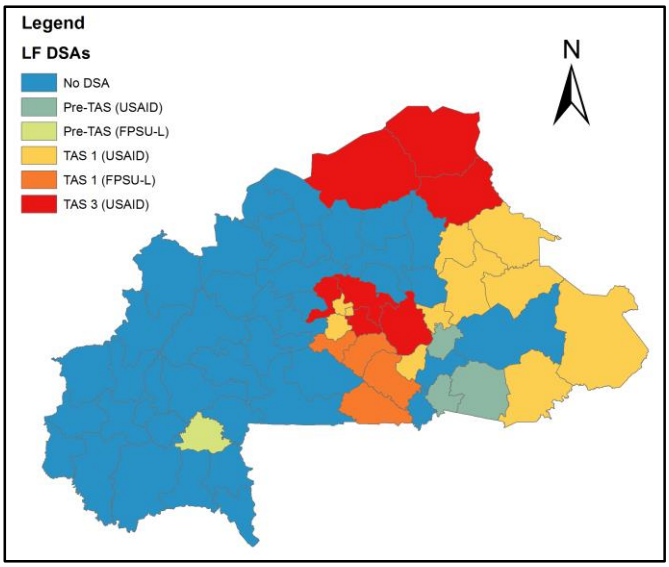
Table 10: Cross-Portfolio Requests for Support

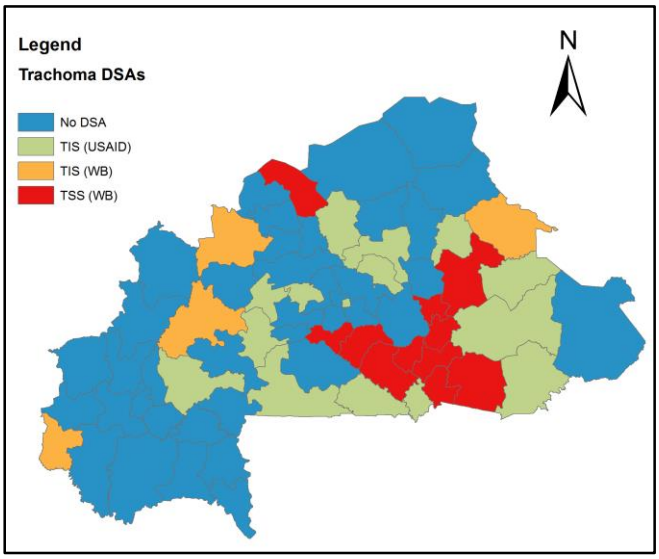
Identified Issue/Activity for which support is requested.	Which USAID partner would likely be best positioned to provide this support?	Estimated time needed to address activity
Survey on socio-demographique characteristics of positive cases from pre-TAS in 3 sentinel sites.	Research	7 days

The NTDP proposes undertaking an investigation of cases testing positive for mf during the pre-TAS surveys to better understand their characteristics. In certain regions of Burkina Faso (Est, Centre-Est, Centre-Sud, Centre-Ouest, and Sud-Ouest), persistent pockets of LF have been found. In certain districts in these regions, mf prevalence remains high and the districts unable to meet the criteria to conduct TAS 1, despite the fact that between 13-20 rounds of MDA have been conducted. The NTDP therefore would like to further investigate the socio-demographics of the positive cases in order to determine if there are specific programmatic actions that can be taken. For FY17, the NTDP proposes to select three of the sentinel sites in these regions, and expand this investigation to other sentinel sites at a later time point.

Maps

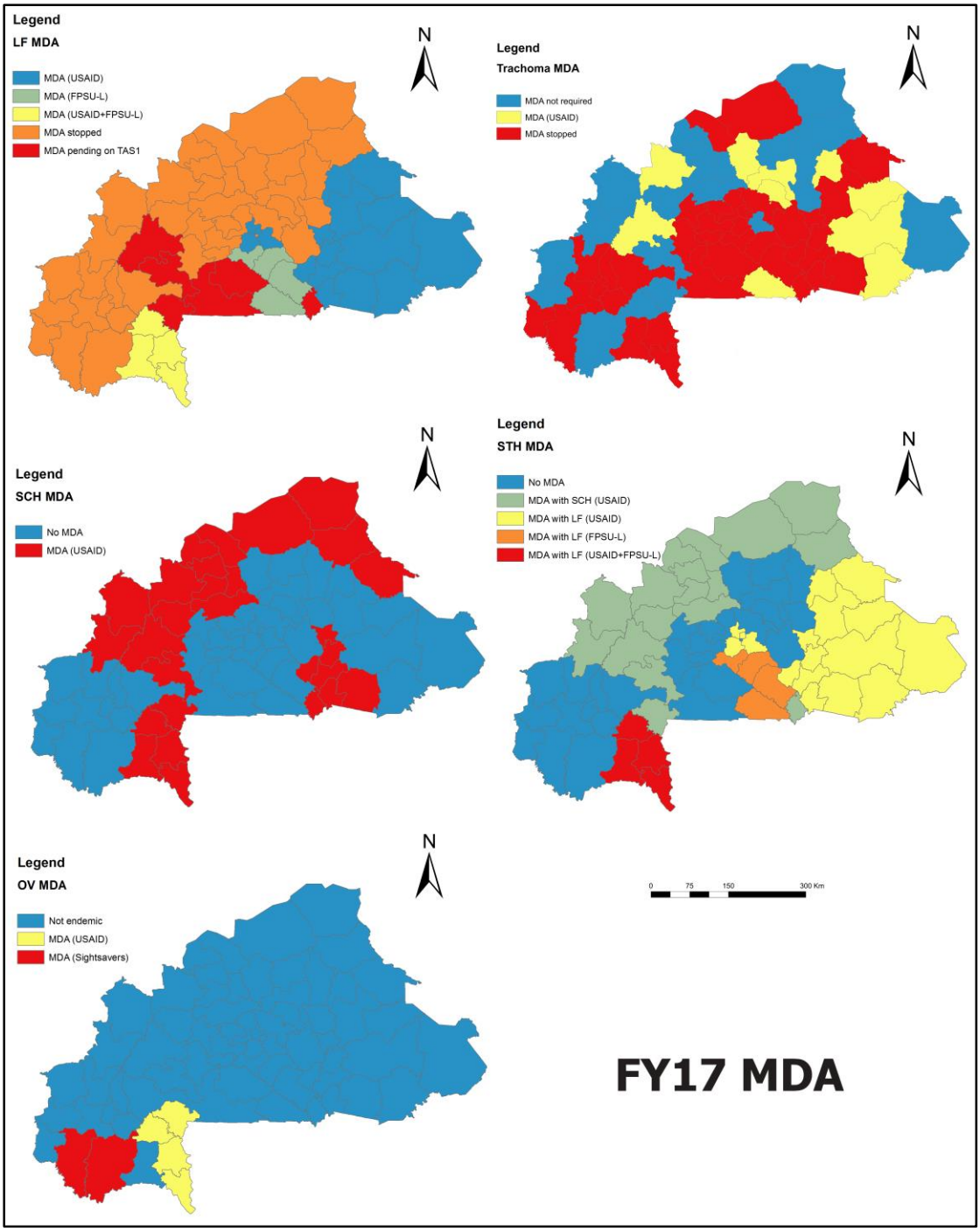






Note:

- TIS=trachoma impact assessment;
- TSS=trachoma surveillance survey



Note: the trachoma MDA is contingent upon results of impact assessments, which are planned in 19 HD in early FY17

APPENDICES

1. **Country staffing/partner org chart**
2. **Work plan timeline**
3. **Work plan deliverables**
4. **Table of USAID-supported provinces/states and districts**
5. **Program Workbook**
6. **Disease Workbook**
7. **Country budget**
8. **Travel Plans**