Burkina Faso

2012 OPERATIONAL PLAN

FOR CONTROL OF NEGLECTED TROPICAL DISEASES

IN BURKINA FASO

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ACRONYMS AND ABBREVIATIONS

ALB	albendazole
BCC	Behavior change communication
CDD	Community drug distributor
CDTI	Community Directed Treatment with Ivermectin
CFA	Circulating filarial antigen
CHR	Regional hospital
CHU	University teaching hospital
CMA	Medical center with surgical unit
CMFL	Average concentration of microfilaria
CNTD	Center for Neglected Tropical Diseases
CSPS	Health and social promotion center
DEP/MATD	Research and planning department /Ministry of territorial administration and decentralization
DGISS	General Information and health statistics directorate
DLM	Disease control department
ECD	District team
FCFA	Franc de la Compagnie Financière de l'Afrique
FDC	Foundation for Community Development
GSK	GlaxoSmithKline
HD	Health district
HDI	Health and Development International
HI	Handicap International
HKI	Helen Keller International
HDI	Human development index
ICP	Health post nurse
IEC	Information education communication
IVM	ivermectin
ITI	International Trachoma Initiative
LF	Lymphatic filariasis
M&E	Monitoring and Evaluation
MDA	Mass Drug Administration
MDP	Mectizan Donation Program
MDSC	Pluripathological surveillance center
MOH	Ministry of Health
NGO	Non-governmental organization
NPCNTD	National Program to Control NTDs
NTD	Neglected tropical disease
OCP	Onchocerciasis Control Program
ONCHO	Onchocerciasis
PCT	Preventive Chemotherapy
PNDS	National health development plan
PNEFL	National program for elimination of lymphatic filariasis
PNLO	National onchocerciasis control program
PNLSc	National schistosomiasis control program
PNPC	Blindness control program
PREV	Prevalence

PSN	National health policy
PZQ	praziquantel
RGPH	General population census
RHD	Regional health department
SCI	Schistosomiasis Control Initiative
SNIS	Health information system
STH	Soil-transmitted helminthiasis
TAS	Transmission assessment surveys
TF	Follicular trachoma
TT	Trichiasis trachomatis
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Neglected tropical diseases (NTDs) can adversely affect the health and socio-economic development of individuals and their families, as well as the development of endemic districts, regions, and countries. Burkina Faso is committed to the fight against lymphatic filariasis (LF), onchocerciasis, schistosomiasis, soil-transmitted helminthes (STHs), and trachoma. In the next year of the National NTD Control Program (NPCNTD) , Burkina Faso will continue to attain 100% geographic coverage in treating populations at risk for the 5 target diseases and aims to reach above "adequate" disease specific thresholds for program and epidemiological coverage through mass drug administration (MDA). MDAs are planned to take place in various phases beginning in May 2012 and ending in September 2012 in 57 districts for LF, 44 for schistosomiasis, 23 for trachoma, and 6 for onchocerciasis with about 13 million people targeted for treatment with one or more drug packages.

Past efforts in social mobilization, advocacy, and the use of information, education and communication (IEC) materials will continue through the NTD Control Program to achieve program objectives across endemic districts. A targeted effort on freeing up funds for morbidity management within the State will be made, using gains in preventive chemotherapy as a platform. Community mobilization strategies currently in place (posters, fliers, banners, media campaigns, public service announcements, among others) will expand to include behavioral change communication (BCC) messages and the development of an integrated communication plan.

The NPCNTD will continue to monitor the impact of previous years of the program on the prevalence of diseases with elimination targets through impact studies for trachoma, sentinel site and control site studies for LF and transmission assessment studies for LF. The monitoring and evaluation (M&E) mechanisms employed will enable the program to identify the districts where treatment can be stopped and those where a change of strategy may be necessary.

Overall, the country will use past lessons learned to drive future progress, ensuring that the NTD control program strategy is aligned with the national health development plan (2011- 2020) under health promotion and disease control, bringing Burkina Faso closer to achieving long-term goals in NTD control, elimination and post-endemic surveillance.

Background

National programs in LF, onchocerciasis, schistosomiasis, STHs and trachoma have been working together under the integrated NPCNTD in Burkina Faso since 2007. Mass drug administration (MDA) campaigns with different drug packages have been conducted throughout the country. Table 1 reflects the current situation of NTD control in the country pertaining to known disease endemicity, mapping, and MDA.

- LF is endemic in all 63 districts, and annual MDA with ivermectin (IVM) and albendazole ALB started in 2001 and reached national geographical coverage in 2005. Currently MDA for LF has been stopped in 6 districts, but ongoing in 57 districts. Epidemiological surveys are now needed to assess whether districts are qualified for transmission assessment surveys (TAS), or for stopping MDA. 43 of the 57 districts will be treated with USAID funds for LF while the remaining will be funded by Center for Neglected Tropical Diseases (CNTD) Liverpool and the Government.
- Onchocerciasis is endemic in only 6 districts which are fully targeted by LF MDA, and only surveillance activities are required.
- STH is present in all 63 districts, which also benefits from LF MDA in 57 districts, while STH MDA with ALB is required in 6 districts, where LF MDA has been stopped, and this is integrated with praziquantel (PZQ) MDA for schistosomiasis.
- Schistosomiasis is endemic across the country in 63 districts. MDA with PZQ started in 2004 in 4 regions (19 districts) and in 2005 in the rest of the country (44 districts). Such arrangements have continued to form a biennial MDA for schistosomiasis control. Evaluation of the current endemic situation is needed.
- Trachoma is endemic in 30 districts, which qualified for MDA intervention. Impact studies were conducted in 7 districts and awaiting validation of the results; 23 districts are planned for further MDA in 2012. Impact studies are planned in 11 districts in 2012 but we will also plan to treat these districts as recommended by the International Trachoma Initiative (ITI). There are 8 districts that have been given approval for treatment by the ITI in 2012 – these 8 will receive zithromax in the pending shipment. The additional 4 require evidence of SAFE strategy activities before approval can be granted and drugs can be shipped. For the 11 districts where impact studies are planned, ITI has placed drugs in reserve – if impact study results warrant district-level treatment, additional zithromax will be shipped.

Table 1 Current snapshot of NTD control in Burkina Faso pertaining to disease endemicity, mapping, and MDA

Disease	Number of endemic districts	Number of non-endemic districts	Number of districts needing mapping	Number of districts with ongoing MDA	Number of districts needing MDA, but MDA not yet started
Lymphatic filariasis	63	0	0	57	0

Disease	Number of endemic districts	Number of non-endemic districts	Number of districts needing mapping	Number of districts with ongoing MDA	Number of districts needing MDA, but MDA not yet started
Onchocerciasis	6	57	0	6	0
Schistosomiasis	63	0	0	63	0
Soil-transmitted helminthes	63	0	0	63	0
Trachoma	30	33	0	23	0

Outcome and results of the 2011 campaigns

Activities for controlling NTDs in 2011 focused on MDAs and the results have been submitted to FHI 360/USAID. The NTD campaigns conducted were:

- MDAs to treatLF, onchocerciasis and STH (IVM +ALB) in 6 health regions or 26 health districts. Treatment against onchocerciasis was conducted in four districts in the South-West region and 2 districts in the Cascades region.
- Mass treatment for schistosomiasis using PZQ in 4 hyper-endemic regions, comprising a total of 19 health districts as part of the above-described biennial approach to MDA for schistosomiasis.
- Treatment for trachoma using azithromycin targeting 19 health districts in 10 regions, ended in October, 2011.

The challenges of the 2011 campaigns included the following:

- Multiple postponement of the campaign dates.
- Weaknesses in the execution of the social mobilization/IEC/BCC campaigns.

The Ministry of Health (MOH) and HKI will address these challenges and will be using the lessons learned from them to improve the 2012 campaign.

Objectives for 2012

In accordance with the National NTD Control Strategic plan, the NPCNTD developed the following objectives:

- Intensifying the coordination and partnership for the control of NTDs
- Attaining at least 80% program coverage and 100% geographical coverage for the MDA againstLF, onchocerciasis, schistosomiasis and STH and attaining at least 90% of program coverage and 100% geographical coverage for the MDA against trachoma
- Implementing M&E and surveillance activities for NTDs

- Reaching the populations of the endemic zones through IEC on NTDs

Main activities for 2012[1]

Activities by objective are:

1. Intensifying the coordination and partnership for the control of NTDs

- Create an organized coordination structure within the national NTD program (a national coordinator has now been appointed by the MOH).
- Support the functioning of the coordination structure of the national NTD program.
- Hold a semi-annual meeting of the Steering Committee of the End in Africa NTD project in Burkina Faso (MOH, HKI, FHI 360, Foundation for Community Development (FDC), Handicap International (HI), Sightsavers).
- Hold a quarterly meeting of the technical working group (HKI and the national NTD program).
- Hold a monthly coordination meeting of the national NTD program, HKI, and other stakeholders.
- Hold an annual review of the NTD program with the partners at the national level.
- Disseminate quarterly and annual reports to all NTD stakeholders on activities of the NTD program.
- Organize a workshop to develop the 2013 USAID annual work plan.

2. Reaching at least 80% program coverage and 100% geographical coverage for the treatment of lymphatic filariasis, onchocerciasis, schistosomiasis (at least 75% among school age children) and STH and reaching at least 90% of program coverage and 100% of geographical coverage for MDA against trachoma.

- Train those involved in NTD control activities at all levels of the health system.
- Provide health structures with sufficient quantities of the necessary medications and support for data collection.
- Supervise the implementation of MDA campaigns at all levels.
- Administer drugs to the populations by community distributers during the MDA campaigns.
- Reproduce data collection tools.
- Collect data on mass treatment campaigns at all levels.
- Hold evaluation meetings after the NTD campaigns at the regional and central level.

3. Implementing M&E and surveillance of NTD activities.

- Train bio-medical technicians in the diagnosis and surveillance of NTDs.
- Collect data in the sentinel sites of the NTD programs.
- Conduct pre-TAS sentinel site/spot check site assessments and TAS for LF in the eligible districts (Table 2).
- Conduct epidemiological surveys in basins formerly endemic to onchocerciasis.

4. Reaching populations of endemic zones with IEC on NTDs

- Develop an integrated communication plan for NTDs.
- Organize the official launching of the NTD campaigns with the participation of the different partners.
- Conduct advocacy in favor of the NTD control among the administrative, political, traditional and religious authorities.
- Organize information and sensitization meetings among the media.
- Conduct media campaigns for the control of NTDs.
- Inform and sensitize the communities on NTD activities through the use of town criers.
- Provide the distributors and others who play a key role in social mobilization with IEC materials.

[1] The detailed activities and periods of execution are contained in the chronogram attached as annex.

Additional details for each activity objective can be found in the following sections of this work plan.

Projections and scaling up

Full geographic coverage has been reached in Burkina Faso, therefore scale-up is not anticipated in 2012.

Mapping

All mapping is complete.

Mass drug administration (MDA)

Depending on the target diseases, the implementation of MDA and monitoring activities is planned as follows:

Table 2: 2012 Plans on implementation of MDA and monitoring/evaluation

	LF	SCH	Trachoma	ONCHO
Number districts to be treated	57	44	23	6
Stop MDA Study	9 funded by USAID (and 5 funded by CNTD Liverpool)	To be discussed per new WHO guidelines	11	NA
Population to be treated (national census data projected to 2012)	12,278,978	3,683,846	6,128,596	382,906***
Health Districts(HD) in surveillance*	6	-	-	

*This activity does not have an impact on the budget. Details of health districts be treated in 2012 per disease are provided in the 2012 work plan workbook.

*** The targets for Onchocerciasis treatment are determined by census before the MDA. The Community Directed Treatment with Ivermectin (CDTI) is supported in the South-West region by HKI/FHI 360 and in the Cascades region by Sightsavers.

The WHO treatment protocol is followed for all diseases except for schistosomiasis. For schistosomiasis, every two years, school school-aged children are treated in meso-endemic districts and the whole population over 5 years of age is treated in hyper-endemic districts. This follows the recommendations from the Schistosomiasis Control Initiative and the London School for Tropical Medicine.

Table 3 – Protocols of Treatment in Burkina Faso

	LF	STH	Schistosomiasis	onchocerciasis	Trachoma
Age group targeted	> 5 years old	5-14 years old	≥ 5 years old in hyper-endemic districts 5-14 years old in meso-endemic districts	> 5 years old	The whole population
Frequency	Once a year	Once a year	Once every two years	Twice a year*	Once a year
Distribution platform	Community based (door to door) but also in schools, fix posts in the health centers.	Community based (door to door) but also in schools, fix posts in the health centers.	Community based (door to door) but also in schools, fix posts in the health centers.	Community based (door to door) but also in schools, fix posts in the health centers.	Community based (door to door) but also in schools, fix posts in the health centers.

*The second round is funded by USAID/CNTD Liverpool and the MOH in the South-West and by Sightsavers in the Cascades

In the usual pattern, MDAs are conducted within a 2-week interval between March and April. However, this year, the PZQ is planned to arrive late April and MDAs had to be shifted to May to take this new parameter into consideration. In addition, it is not possible to conduct the trachoma MDA until the results of the impact surveys are available and these surveys can only be conducted 6 months after the latest MDAs. As a result, in 11 districts, the trachoma MDA cannot be implemented before July and since it is the start of the rainy season, it had to be postponed to September. In September, there will also be the second round of onchocerciasis/LF MDA in the South-West (where transmission of both diseases is still considered high due to cross-border transmission issues with Côte d'Ivoire). The other two onchocerciasis districts will also be treated in September but these MDAs will be funded by SightSavers.

Table 4 presents the schedule of the 2012 campaigns. The delivery methods include the following:

- School-based delivery: 1) health agents distribution (supervised by the MOH), or 2) teacher distribution--they receive the same training and supervision as community drug distributor (CDDs).
- CDD distribution: community-based delivery including door to door and central point distribution (i.e., markets, prisons, barracks, and other public locations).
- Fixed site health center based distribution in the Centers of Health Promotion (CSPS).

Table 4: Schedule of 2012 campaigns.

Distribution campaign	Period	Duration	Health regions	Number of health districts
LF, onchocerciasis and STH (ALB +IVM)	May 2012	7 days	13	57
	September 2012	7 days	1	4*
Schistosomiasis	May 2012	7 days	8	38

Distribution campaign	Period	Duration	Health regions	Number of health districts
(PZQ)				
Schistomiasis, STH (both school and community based) (PZQ+ALB)	May 2012	7 days	1	6
Trachoma (azithromycin or tetracycline)	September2012	7 days	6	23

* Due to high transmission levels, both WHO and the LF Support Center has recommended to treat 2X year in these 4 districts.

IEC/Social mobilization

In order to ensure public compliance with the MDA campaigns, policy-makers and leaders of NTD control and communication activities have planned the following:

- Advocating for the project among administrative, political, traditional and religious authorities. These initiatives will be conducted in the capital cities of the targeted regions and districts.
- Developing an integrated communication plan:
  - Holding two informational meetings at the regional level with the media on NTDs and the side effects of drugs.
  - Conducting BCC activities promoting the control of NTDs (e.g., media campaigns, public service announcements) organized by the NPCNTD.
  - Developing and reproducing IEC materials (e.g., posters, flyers, banners, T-shirts, caps) for dissemination to the health centers and CDDs.
- Organizing the annual launch of mass treatment campaigns in collaboration with the MOH.

Supply chain management

Each level of the health system (region, district, health facility and village) will be provided with the necessary inputs. The MOH and HKI will identify the need for dose poles, registers, data collection tools and drugs. Working sessions will be held between the NPCNTD and HKI to address more specific needs.

Central Level:

The pharmacist of the directorate for the fight against diseases will identify a central warehouse prior to the arrival of drugs into the country where the drugs can be stored while awaiting distribution to

the health districts (HD). The warehouses must meet acceptable quality expectations. Trucks will be rented for delivering MDA materials to the intermediate and peripheral levels. The national level will prepare for the allocation of resources (fuel, handling and mission fees, road taxes, stock replenishment) to the HDs and regional health districts (RHDs) for delivery of inputs.

Regional/District Level:

At the regional/district level, the regional pharmacists will be informed of quantity of drugs, the expected date of delivery, and the necessary warehouse conditions required. Each district will designate a warehouse for the drug storage.

Local level:

From the district warehouse, the drugs will be sent to health center drug stores. CDDs will take the drugs from the health center drug stores.

Transport of drugs to the districts will need to be staggered this year as a result of delayed applications to drug donations organizations. This was due to the delays of the MDA in 2011 and not having the necessary information on remaining stocks to allow for a timely submission.

Table 5: Estimation of drug needs for 2012

Drugs	Source of drugs (bought or donated)	Quantity of drugs purchased or donated	Date of application (Month/year)	Expected date of delivery of drugs
(IVM	Merck	36,778,660	October 2011	Jan-Feb 2012
(ALB(for LF MDA)	GSK	13,505,023	October 2011	Jan-Feb2012
ALB (for STH in 6 health districts where LF MDA will not be conducted)	GSK	484,491	December 2011	April 2012
PZQ	USAID	9,104,701	September 2011	April 2012
Zithromax	ITI/PFIZER	6,645,424 cp 4,934,721 sp	November 2011	March –April 2012
Tetracycline ointment	Government	109,660	November 2011	Feb -March 2012

Training

To ensure high quality distribution campaigns and promote compliance with the national guidelines on MDAs, training sessions are organized at all levels (i.e., central, regional, district and community and school levels).

These integrated training sessions at the central, regional and district levels are organized during a single session and take into account all the treatment campaigns at the same time. The training sessions for CDDs are conducted by the health post nurse and are not integrated. They are specific to

each distribution campaign due to the low level of education of the CDDs. The table below indicates the different training courses that will be held in 2012. Pilot testing integrated training will be discussed with the national NTDCP as a way to reduce costs in the future.

Table 6: **Training sessions by level on NTDs in 2012**

Level of implementation	Themes	Number of trainers	Number of persons to be trained/ retrained	Numb er of days	Venue	Nature of the training
Central level Training targets: health region doctors, regional pharmacists and the person in charge of epidemiological surveillance and statistics at regional level	Training/retraining of trainers on MDA (Training focuses on the diseases, the programs, the implementation of the guidelines and the MDA implementation strategies)	7	46	3	Kombissiri	Training and retraining
	Capacity building of the pharmacists on drug quantification, storage and management, management of unused drugs and disposal	4	30	4	Ouaga	Training and retraining
Regional level Training targets: health district doctors, person in charge of epidemiological surveillance and statistics at district level, pharmacist of the health region and the health districts, and sanitation technicians	Training/retraining of trainers on implementation of MDA (on the diseases, the programs, the implementation of the guidelines and the MDA implementation strategies)	30	210	2	Capital of 13 regions	Training and retraining
District level Training targets : head nurses of the health	Training/retraining on implementation of MDA (on the diseases, the	140	2117	2	Capital of the HCs	Training and retraining

Level of implementation	Themes	Number of trainers	Number of persons to be trained/ retrained	Number of days	Venue	Nature of the training
	programs, the implementation of the guidelines and the MDA implementation strategies)					
CSPS level (CDD) Training targets: CHWs, health agents and teachers Note: for the most part the same CDDs participate in all MDAs	Training/retraining on implementation of MDA (Training focuses on the targeted disease, the program, the implementation of the guidelines and the MDA implementation strategies)	2117	40,914 (FL, oncho, STH) 12,702 (schisto; STH) 800 (oncho in Cascades funded by Sightsavers) 4 782 (trachoma)	1	1800 Health facilities	Training/re training

By level, the targets of each session are:

- **Regional Health District level**: heads of health districts, drug managers (pharmacists and pharmacy technicians) and data management officials of each health district are invited to this training or retraining session. It is difficult to determine the number of people for retraining and those for training as attrition is high and it is often not known until the last minute if the training is for new personnel or ones that have already received training.

- **District health level**: the training session will include health nurses in all health facilities of the district concerned. Teachers will also be trained during the training of community distributors, for the distribution of praziquantel, and praziquantel and ALB in the 6 districts where LF MDA has stopped.

- **Health center level**: the different sessions planned will include community distributors and represent all the treatment campaigns during 2012. The training session of CDDs of Onchocerciasis villages in the Banfora and Mangodara HDs will be implemented by Sightsavers.

Supervision

Guidelines for implementation of the MDAs are developed and updated each year (with latest WHO guidelines) and provided to the stakeholders. Cascade supervisions from the central level to the

community level help to monitor the application of the guidelines, correct identified weaknesses, and verify the strict application of the national protocols and WHO standards.

Supervisors from the central level will visit the different health regions up to the level of the distribution site. A sample of district and health centers will be visited by the national supervisors to ensure the effective implementation of the activities. The staff of the regional health department will also train supervision teams who will visit all the districts where treatment campaigns will be undertaken. During the distribution period, the teams from the Regional Health Departments (RHDs) will visit the peripheral health centers and community distributors in the villages. Each supervision team will carry a stock of drugs, IEC tools, data collection tools, and guidelines to assist the team..

The district teams, with the support of resource persons, will determine the supervision visits to cover all the peripheral health facilities. To assure the quality of the MDAs, the chief nurses will supervise all the CDDs during the distribution of drugs. Depending on the number of villages in the catchment area, a nurse could supervise between 16-40 CDDs. Supervision visits to the distribution sites help ensure that the CDDs comply with the national protocols and recommendations by WHO for each drug package. Supervisors are also monitoring whether distributors have sufficient supply of medicines. They will also maintain a back-up supply of drugs.

The following elements are also addressed during the supervision visits:

- Agenda of MDA activities Status of distribution of inputs
- Communication activities

Exchanges with the different actors during the MDAs will help to assess their knowledge of the national guidelines on NTDs (the method of calculation, determination of the target for each campaign, management of refusal/reluctance cases, and management of side effects especially severe adverse events).

Supervision by HKI and the other partners

During all the MDA campaigns, teams of supervisors from HKI and NGOs, notably Foundation for Community Development (FCD) and Handicap International (HI), will monitor the implementation of the distribution at each level. This supervision will ensure the effective application and quality of the distribution and allow for partners to understand the difficulties encountered in the field and the opportunity to propose adequate solutions. Partner supervisory involvement will help assess that USAID and FHI 360 requirements are met.

Central Level

At the central level, higher officers from the MOH and members of the different NTD programs serve as national supervisors and supervise the members of the RHD teams.

RHD Level

The members of the RHD (with the regional pharmacist) supervise members of the executive teams (3-4 people from health district director, pharmacist, data manager, immunization officer, reproductive health officer, BCC officer, etc.) of each district at least twice during each distribution.

District Level

The core teams of the district will supervise members of the teams from the health facilities during each mass treatment campaign and will ensure:

- Training sessions are organized
- CDDs received drugs and MDA materials
- Drugs are disseminated properly:
  - Special attention will be paid to the rates of drug loss.
  - For azithromycin, the CDDs receive the drugs daily and will provide the empty packages upon return.
- Excess drugs are disposed according to the environmental monitoring plan
- Drug dissemination is recorded properly

Particular emphasis will be placed on the understanding on how to calculate the needs of drugs, dosages, and implementation of the social mobilization and sensitization activities. Special attention will be paid to the rates of drug loss, the application of the supervised intakes and the management of side effects. The head nurses will be re-informed about when to transmit reports and remaining stocks of drugs and the necessity for updating the coverage data of all the MDAs on the village treatment registers.

There is a daily monitoring of drugs at every level. With this information, the number of people treated is compared to the quantities of drugs used. For azithromycin, the CDDs receive the drugs every day and they have to provide the empty packages when they come back. These are disposed according to the environmental monitoring plan. During supervisions, the management of drugs is evaluated.

Technical Assistance

Following the evaluation workshop of the distribution campaign of November 2011, the needs expressed are summarized in Table 7.

Table 7: Technical assistance needs

Activities/Needs	Technical skills required	Number of days required	Justification/context
Training of biomedical technicians for diagnosis of NTDs	Laboratory skills to diagnose the target heliminthic infections (LF, oncho, SCH, STH)	7 days	To support the impact studies planned as there are few technicians skilled in lab techniques for the target diseases. Those with training require refresher training courses.

Activities/Needs	Technical skills required	Number of days required	Justification/context
Training of program staff in the monitoring/evaluation of NTDs (WHO Afro training)	Program M&E of NTDs and data driven decision-making based on outcomes	7 days	As the program matures, more focus will need to be placed on monitoring and evaluating program outcomes and targeting efforts for elimination and/or sustained control.
Assisting the NTDCP in the planning and execution of post-trachoma endemic surveillance	Experience in setting up trachoma surveillance sites	5 days	As BF has begun and will continue trachoma impact studies, many districts are anticipated to be below the public health threshold. This will require surveillance to detect any recrudescence of disease.
Supporting the NTD program in validation of data of the impact studies conducted in 7 health districts	ITI team and NTD HKI official	7 days	Discussions on the protocol used. Validation of the data collected in the 7 HDS surveyed in 2009
Training of beneficiaries on procedures for managing USAID funds	Knowledge of USAID rules and regulations	3 days	With changes in the management of USAID funds and with little transfer of ownership to the government on the part of the previous sub-grantee, it is essential that all recipients and users of USG money have at least a basic knowledge on the stewardship of fund.
Financial Gap Analysis Tool (FGAT)	Training and implementation of FGAT	7 days	With increased partner support and expectations of government ownership, the roll-out of the FGAT will help achieve the elimination/control objectives.

Financial management

The management and monitoring of the funds will be done in strict compliance with USAID regulations. To that end, a monitoring plan has been developed in accordance with the regulations and in the framework of USAID's requirements for sub-contracts with the MOH. The process to be followed is described as follows:

- The Disease Control Department of the MOH receives detailed budgets and the terms of reference for activities from the RHDs, which are then validated by the National Technical Coordination for Implementation of the NTD project.
- For each request, a funding agreement is signed between the different RHDs concerned, signed by the Regional Director himself and HKI, represented by the Country Director.
- Once the funding agreement has been signed, the Finance and Accounts Department of HKI is contacted. The Finance Department then issues a check in the name of the RHD. The representatives of RHDs sign a receipt of the check. Checks are never issued in the name of individuals.
- During the execution of the campaigns, monitoring/supervision missions by HKI are conducted in the field to ensure, among other aspects, the effectiveness of the implementation of the activities. The RHD has 45 days following the completion of each activity to submit a technical and financial report to HKI accompanied with all supporting documents for all expenditures engaged in the framework of the activities under the campaign. The format used for these reports must be consistent with the format provided by HKI; the managers of the different RHDs and Districts have been trained in the use of these reports.
- At the time of the justification, the RHDs are obliged to issue a check for the remaining amount when the resources have not been fully exhausted.

After receiving the supporting documents, the financial assistant of HKI verifies all the documents and then prepares a summary sheet of all expenditures by RHD. A monthly financial report is prepared. The report provides the following information: total amount per major budget heading allocated, total expenditures for the period concerned, total expenditures for previous periods and remaining funds. After analyzing all these support documents, the financial and accounts department of HKI sends a letter to the different administrative and financial services to inform them about the validation of their documents.

Financial sampling & Capacity building Assessment

HKI will perform financial sampling on records following an MDA. Upon completion of the MDA activities, the original receipts and other expenditures will flow from the MOH system to HKI for review and certification. FHI 360/Regional Hub (Deloitte) will in turn conduct financial sampling using HKI's financial data immediately after the reviews and certifications. FHI 360 will then advise HKI on areas needing improvement and/or corrective action after the sampling reviews.

TIPAC

Once the new tool for integrated planning and costing (TIPAC) tool is finalized and translated in French, HKI will discuss with the MOH the rolling out of the new tool.

Management of severe adverse events

A mechanism for monitoring for and case management of severe adverse events (SAEs) is established within the MOH for all health initiatives, including NTDs. A pharmacovigilance committee led by the *Direction Générale des Pharmacies, du Médicament et des Laboratoires* (DGPML) is in charge of the collection, analysis and dissemination of all the information on all cases of side effects. All pharmacists of the NTD programs who manage SAEs are members of this committee.

In Burkina Faso, the templates for notification of SAEs are available in all the health districts. Information on the occurrence of SAEs and their management are contained in the sensitization messages disseminated before, during, and after the campaigns. Serious cases are referred to a medical center with surgical unit/ regional hospital/ university teaching hospital (CMA/CHR/CHU) for management by a medical officer. The notification sheet of a SAE is then completed and forwarded to the higher levels according to prescribed guidelines.

An information and sensitization meeting with media will be planned before the mass treatment campaigns in order to better inform the population about adverse effects and minimize.

For all SAEs, FHI 360 and the donation program will be notified immediately using established mechanisms.

Facilitating the collaboration and coordination

The development of partnership and improvement of the coordination of the NTD program will be done through the execution of the activities planned under objective 1 including the following:

- Advocacy increased funding for the control of NTDs in the State budget.
- Appointment of a national coordinator of the integrated NTD control program.
- Establishment of a functional Steering Committee.
- Holding periodic meetings.
- Production and dissemination of activity reports with all stakeholders.

Cost – effectiveness

Due to the difficulties encountered during start-up and the urgency to complete MDA, there has been little opportunity to fully assess issues of cost-effectiveness. This will be a focus over the coming year. Areas that could be considered are the integrated training of CDDs, rather than drug specific training. This will entail scheduling MDAs so the minimum time exists between MDAs and training to increase the chance CDDs will retain the needed information and will accurately and safely distribute the drugs. As mentioned above, HKI will hold meetings with the NTDCP about piloting this approach.. Another potential cost-effective modification is the integration of PZQ with IVM and ALB. This would minimize concerns about the low literacy level of the CDDs and their ability to retain information. This will also decrease supervision costs. Discussions will be held with the NTDCP about piloting this proposal during work planning meetings. This is critical because there has been strong opposition to the proposed drug integration.

Monitoring & Evaluation

The M&E of the NTD control interventions helps to ensure the achievement of the program objectives. High quality data collection, analysis and translation of data are highly important to the program objectives. For data collection, the following elements are available:

- Validated protocols for data collection;
- Data collection tools;
- Common data transmission channels for health information (SNIS);
- Disease-specific M&E activities.

To assess the quality of the data and validate them, supervision visits are undertaken and assessment meetings on NTDs are organized by the national program. Moreover, a careful analysis of the different reports will be carried out at all levels by the national program to identify the weaknesses in the execution of the NTD control activities.

At the end of each mass treatment campaign, evaluation meetings will be organized at all levels (district, regional, and central) to discuss the lessons learned and make recommendations for future campaigns. Additional objectives of the meetings are to validate the data and provide missing information.

The following M&E activities are planned in 2012:

Lymphatic Filariasis

Sentinel sites and spot check assessment:

These surveys consist of collection of blood samples of a sample of 500 people per village to evaluate the LF prevalence based on the number of positive microfilaremia. This activity is conducted in a sentinel village or in a control village (spot check) in implementation units after at least 6 rounds of treatment. If the prevalence is found to be <1% in both sentinel and control sites, the district is eligible for TAS.

TAS:

According to WHO recommendations, if a district is eligible for the TAS (prevalence in sentinel and control sites is <1%), a survey is conducted among school-aged children to determine the transmission rates (ICT cards) and the need for MDA.

Trachoma

Impact assessments:

According to the former WHO protocol, after 3 rounds of treatment in endemic districts, Follicular trachoma (TF) prevalence evaluation surveys must be conducted to decide if MDAs can be stopped at district-level. This survey is organized in 30 clusters per eligible district.

The data from the trachoma impact surveys were collected in 2010 in 7 districts of the Center-East and the Eastern region. The blindness control program (PNPC) will benefit from funding from the Conrad N. Hilton Foundation to finalize the analysis of these surveys.

Onchocerciasis/STH

Epidemiological surveys:

After 3 rounds of IVM treatment in the onchocerciasis villages, a survey is conducted on a sample of the population to determine the prevalence of onchocerciasis in the village and the microfilaremia concentration.

Schistosomiasis

Sentinel sites

Data collection is conducted with a a sample of students in schools to determine the prevalence of schistosomiasis and other STH in the stools and urine. The purpose is to evaluate the impact of the PZQ and ALB treatment and to compare it to the initial prevalence in the same schools.

A detailed list of M&E activities planned can be found in the 2012 work plan workbook.

Cost-sharing

The annual budgets highlight the contribution of the different stakeholders in the implementation of the NTD program in Burkina Faso. However, this list is not exhaustive. The main sources of funding are: WHO, WHO/APOC, Lymphatic Filariasis Support Center, USAID, CNTD Liverpool, ITI, Sightsavers and the communities.

The contribution by the Government of Burkina Faso is diversified and takes into account the salaries of health workers, and the amounts reserved for the control of NTDs. The TIPAC will help illuminate the extent of other contributions.

Other interventions contribute to the achievement of objectives of the NTD program including the project on trachoma control in schools funded by the Embassy of Taiwan, China.

2012 Travel Plans

Travels planned for the period are aimed at:

- Supporting the participation of the Schistosomiasis Coordinator in the annual meeting of coordinators of the LF elimination programs;
- Supporting the organization of the study tour of the coordinator of the trachoma sub-program in Mali for sharing experiences in stopping trachoma MDA at the district level;
- Six internal HKI support and coordination trips:
    - Two missions by the HKI Director of NTDs: New York – Ouaga.
    - One mission of the Director of Operations of the HKI Regional Office in Dakar, and one mission by the Deputy Regional Director: Dakar – Ouaga.
    - Two missions by the Regional NTD Advisor: Ouaga – Dakar.

Environmental Monitoring Plan

Appropriate measures will be taken to ensure strict compliance with the requirements of the environmental monitoring plan. The program will take measures for the destruction of waste left

over from the MDA campaigns. Empty packages and expired drugs are collected by each health center. The health district drugs management committee records the number of empty packages and/or expired drugs received and authorize the incineration at the health or district levels.

Project Team

The HKI NTD team is now composed of the following team members:

- A Project Coordinator: serves as the interface between the coordination team of the NTD program of the MOH and HKI. He ensures the application of the procedures, the planning, and implementation of the different activities planned under the project. He works in close collaboration with the MOH NTD programs to evaluate the drug requirementsin a timely manner, validate drugs requests, monitor drugs delivery, facilitate customs clearance, and ensure adequate storage at central level. He reports to the Deputy Director. .
- An assistant to the Coordinator: supports the execution of the responsibilities mentioned above.
- A financial assistant: handles the aspects associated with finances and budgets. He follows the execution of the budgets of the project, verifies and validates expenditures.

The core team is comprised of the Director, the Deputy Director, the Finance Officer, and many other support staff such as finance and administration officers, an administrative assistant, driver, secretary, and janitor whose costs are part of HKI Burkina's core costs.

Annex 1: Schedule of activities by objective for 2012

ACTIVITIES	IMPLEMENTATION PERIOD											
	2011			2012								
	O	N	D	J	F	M	A	M	J	July	A	S
1. Strengthening the coordination and patronage for the control of NTDs												
Adopting an order on creation and organization of the coordination structures												
Ensuring the functioning of the coordination												
Holding a meeting of the Steering Committee												
Holding a meeting of the Technical Working Group												
Holding a meeting of the coordination												
Preparing and validating the requests of drugs with JSI support												
Holding a meeting with the partners												
Developing or reviewing the agreements and memoranda of understanding with the partners												

ACTIVITIES	IMPLEMENTATION PERIOD											
	2011			2012								
	O	N	D	J	F	M	A	M	J	July	A	S
Reproducing and disseminating the reports once/quarterly and 1 annual report												
Holding a workshop to develop the 2013 USAID annual work plan												
Training stakeholders on NTDs at all levels												
Supporting the RHDs in the training of ECDs on NTDs												
Supplying health structures with drugs and data collection forms												
Supervising the actors in the implementation of the MDA campaigns at all levels by the MOH.												
Supervising the actors in the implementation of the MDA campaigns at all levels by the partners												
Administering drugs to the populations by community distributors during the MDA campaigns.												
Holding evaluation meetings of the MDA campaigns												

ACTIVITIES	IMPLEMENTATION PERIOD											
	2011			2012								
	O	N	D	J	F	M	A	M	J	July	A	S
Training the biomedical technologists in the diagnosis and surveillance of NTDs												
Collecting data in the sentinel sites of the NTD programs.												
Conducting impact surveys (Trachoma) and TAS (LF) in eligible districts.												
Conducting epidemiological surveys in basins that were formerly endemic to onchocerciasis.												
Developing an integrated communication plan on NTDs												
Organizing the official launch of the MDA campaigns with the participation of the different partners.												
Conducting advocacy activities in favor of NTDs among the administrative, political, traditional and religious authorities.												
Organizing information and sensitization meetings with the media												
Conducting media campaigns for the control of NTDs.												
Informing and sensitizing the communities on MDA activities by public criers.												

ACTIVITIES	IMPLEMENTATION PERIOD											
	2011			2012								
	O	N	D	J	F	M	A	M	J	July	A	S
Supplying beneficiary structures with IEC aids												

Annex 2. Future MDA and M&E Plans

	2013	2014	2015
Lymphatic filariasis			
Number districts to be treated	43	35	0
Stop MDA Study	8	23	0
Population to be treated (national census data projected to 2012)	11,251,764	6,922,749	0
Health Districts(HD) in surveillance	13	20	28
Schistosomiasis			
Number districts to be treated	19	44	19
Stop MDA Study	NA	NA	NA
Population to be treated (national census data projected to 2012)	4,073,091	3,285,292	4,206,464
Health Districts(HD) in surveillance	Na**	NA	NA
Trachoma			
Number districts to be treated	08	04	-
Stop MDA Study	04	04	-
Population to be treated (national census data projected to 2012)	52,378	19,043	0
Health Districts(HD) in surveillance	2,566,507	933,123	0
Number districts to be	11	15	19

treated			
Onchocercosiasis			
Number districts to be treated	6	6	6
Stop MDA Study	NA	NA	NA
Population to be treated (national census data projected to 2012)	6	6	6
Health Districts(HD) in surveillance			