



# **USAID Malaria Program in Burkina Faso**

**Assessment and Work Planning for  
MCHIP and Deliver  
5-16 October 2009**

# Team Members

- Deliver
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  - Bernabe Yameogo, Malaria Advisor, Burkina Faso
- USAID
  - George Greer, Senior Advisor Child Survival and Infectious Diseases, USAID Africa Bureau
  - Paul Sossa, USAID Regional Office, Accra

# Scope of Work

## **Deliver**

- Assess the supply chain capacity for routine delivery of LLINs to peripheral facilities
- Provide technical and logistic support to the LLIN universal coverage campaign
- Procurement of some malaria commodities not including LLINs
- Provide support in pharmaceutical management and logistics again with an initial focus on the LLIN universal campaign

## **MCHIP**

- Assess training needs of new health workers including IPTp, Case Management and ITN promotion
- Identify support supervision practices for health workers at peripheral health facilities
- Assess malaria diagnostic capabilities at referral and primary health care facilities
- Determine Training needs of health workers on appropriate use of RDTs

# Methodology of Assessment

- Review of Documents
  - MOP, GFATM Proposals and Progress Reports, National Strategies, Training Materials and Guidelines, Published Studies and Reports
- Key Informant Interviews
  - Stakeholders at national, regional, district and community levels in both private and public sectors
- Field Visits

# Yako District



District Hospital and  
Yako District Health Office



Petit Samba



Pelegtenga

# Ouahigouya



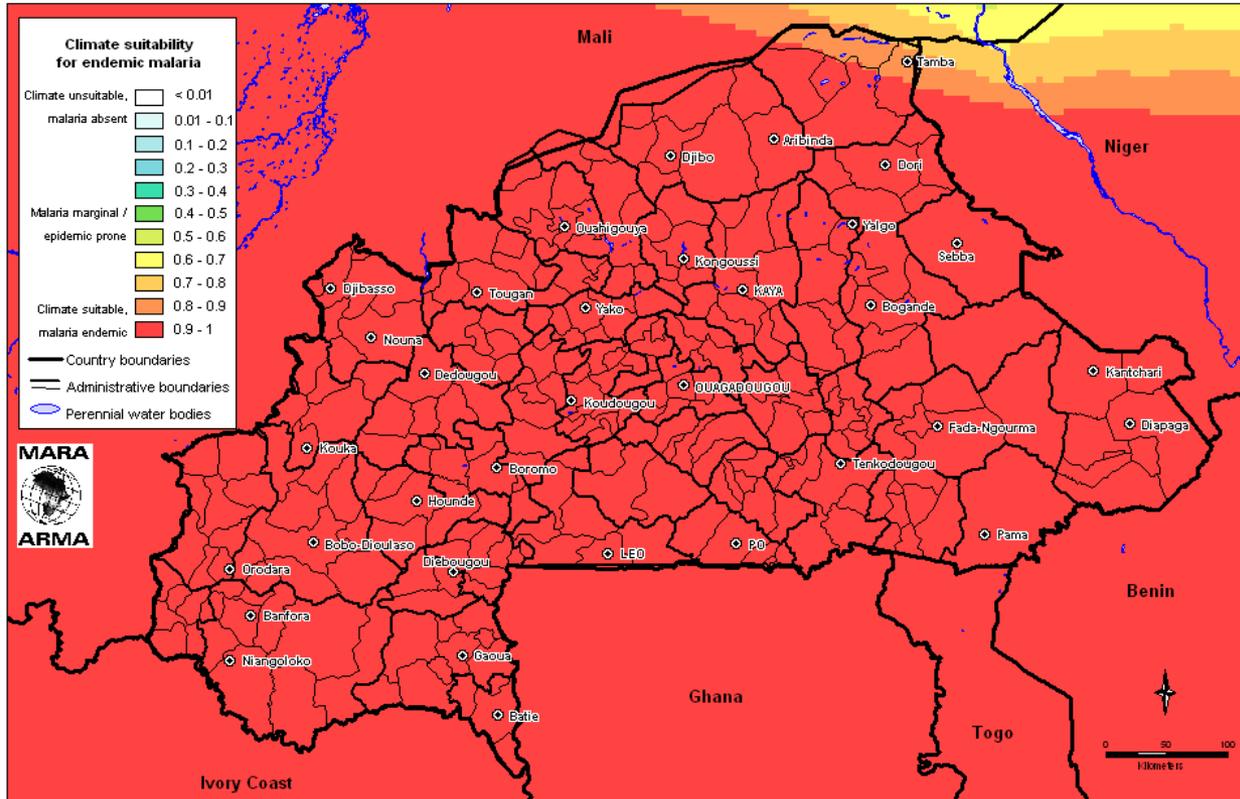
- Regional MOH Headquarters
- Regional Hospital
- Regional Depot for CAMEG
- District Health Office

# Epidemiological Context

- Malaria is endemic throughout Burkina Faso
- Research to support malaria prevalence is very focal
- Generally malaria is recognized as seasonal ranging from 3-7 months
- There may be very focal transmission areas year-round
- How does this information influence planning?

# Distribution of Endemic Malaria

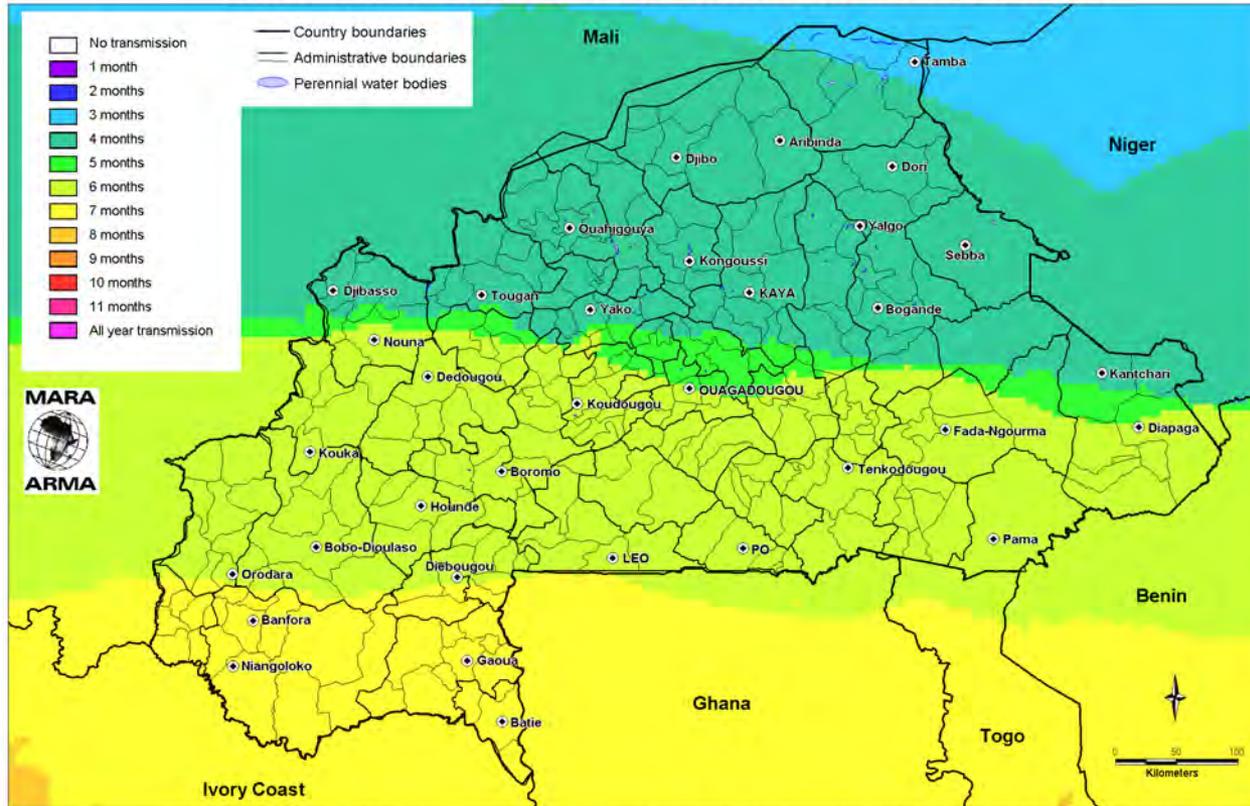
Burkina Faso: Distribution of Endemic Malaria



This map is a product of the MARA/ARMA collaboration (<http://www.mara.org.za>). July 2002, Medical Research Council, PO Box 70390, Overport, 4067, Durban, South Africa  
 CORE FUNDERS OF MARA/ARMA: International Development Research Centre, Canada (IDRC); The Wellcome Trust UK; South African Medical Research Council (MRC);  
 Swiss Tropical Institute, Multilateral Initiative on Malaria (MIM) / Special Programme for Research & Training in Tropical Diseases (TDR), Roll Back Malaria (RBM).  
 Malaria distribution model: Craig, M.H. et al. 1999. Parasitology Today 15: 105-111.  
 Topographical data: African Data Sampler, WRI, [http://www.igc.org/wn/sdis/maps/ads/ads\\_idx.htm](http://www.igc.org/wn/sdis/maps/ads/ads_idx.htm)

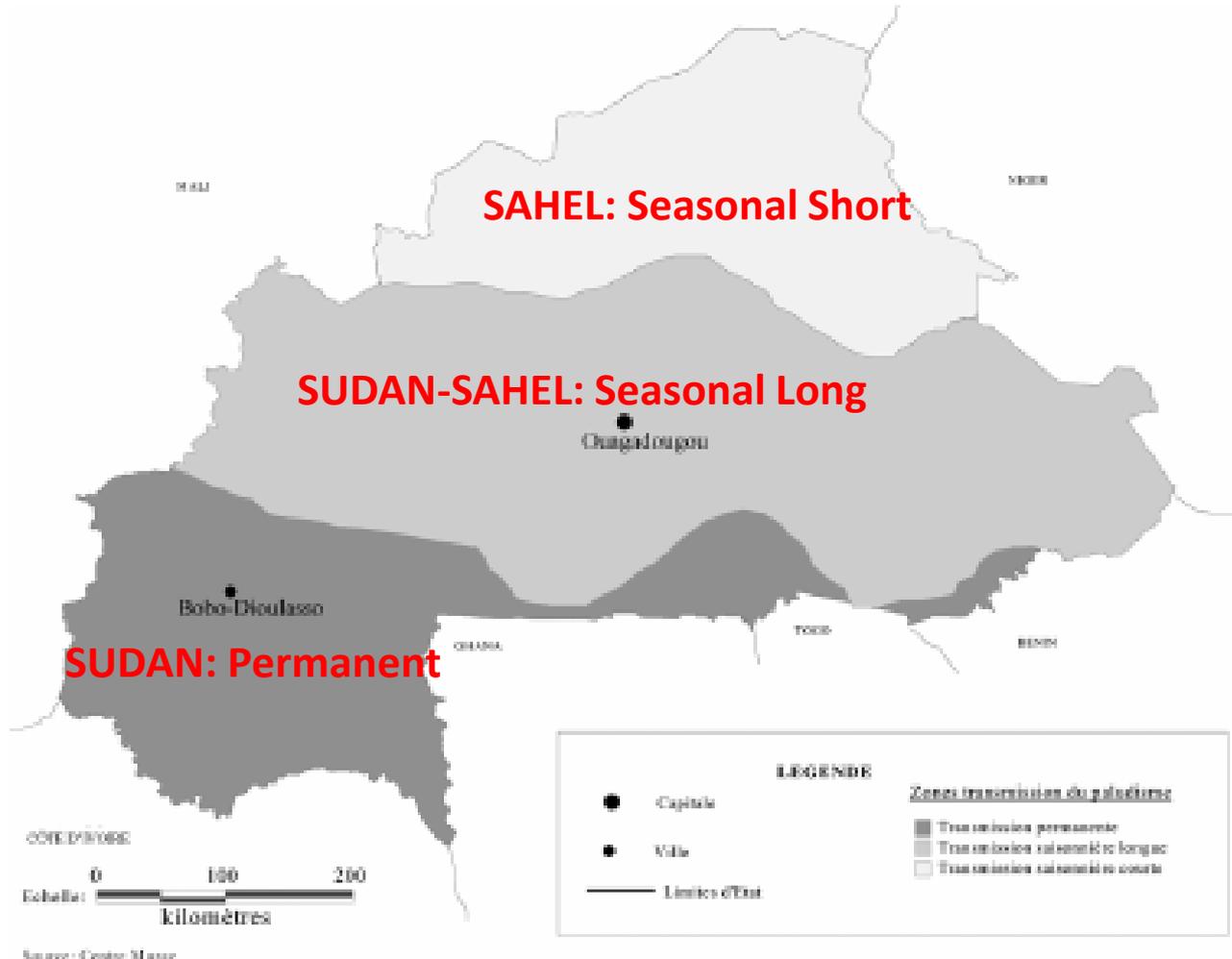
# Months of Transmission

Burkina Faso: Duration of the Malaria Transmission Season



This map is a product of the MARA/ARMA collaboration (<http://www.mara.org.za>). 7 months 2001, Medical Research Council, PO Box 17120, Congella, 4013, Durban, South Africa  
 CORE FUNDERS of MARA/ARMA: International Development Research Centre, Canada (IDRC); The Wellcome Trust UK; South African Medical Research Council (MRC);  
 Swiss Tropical Institute, Multilateral Initiative on Malaria (MIM) / Special Programme for Research & Training in Tropical Diseases (TDR), Roll Back Malaria (RBM).  
 Malaria seasonality model: Tanser, F et al. 2001. Paper in preparation. Topographical data: African Data Sampler, WRI, [http://www.igc.org/wri/sds/maps/ads/ads\\_idx.htm](http://www.igc.org/wri/sds/maps/ads/ads_idx.htm).

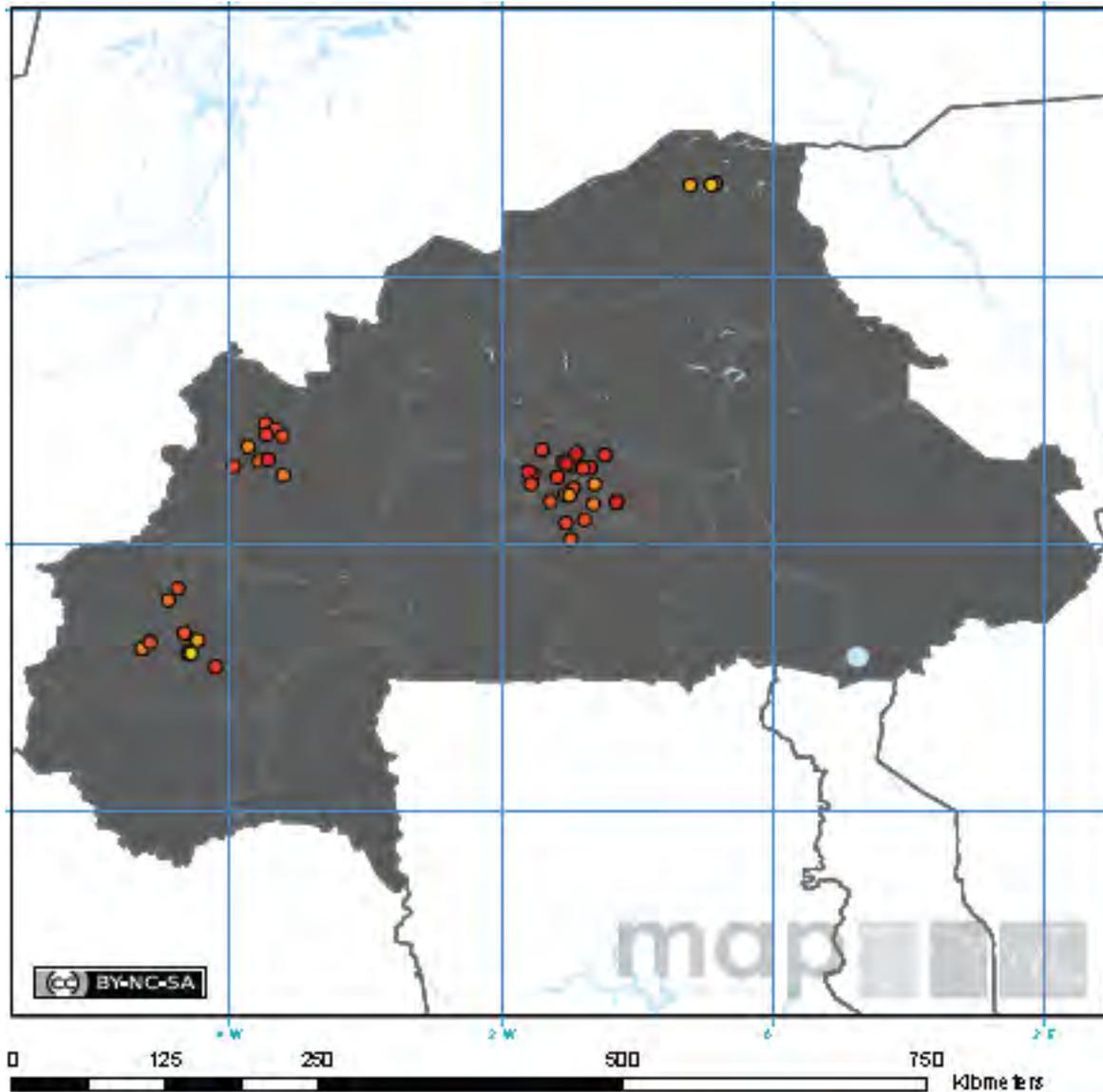
# Three Main Transmission Zones



# Population by Transmission Zone

Zone	Population	<5s	Pregnant	Transmission
Sahel	1,753,464	350,693	70,139	2-3 mos
Sudan-Sahel	9,236,855	1,847,371	369,474	4-6 mos
Sudan	3,991,008	798,202	159,640	>6 mos
Total	14,981,327	2,996,265	599,253	

# Areas where prevalence studies conducted

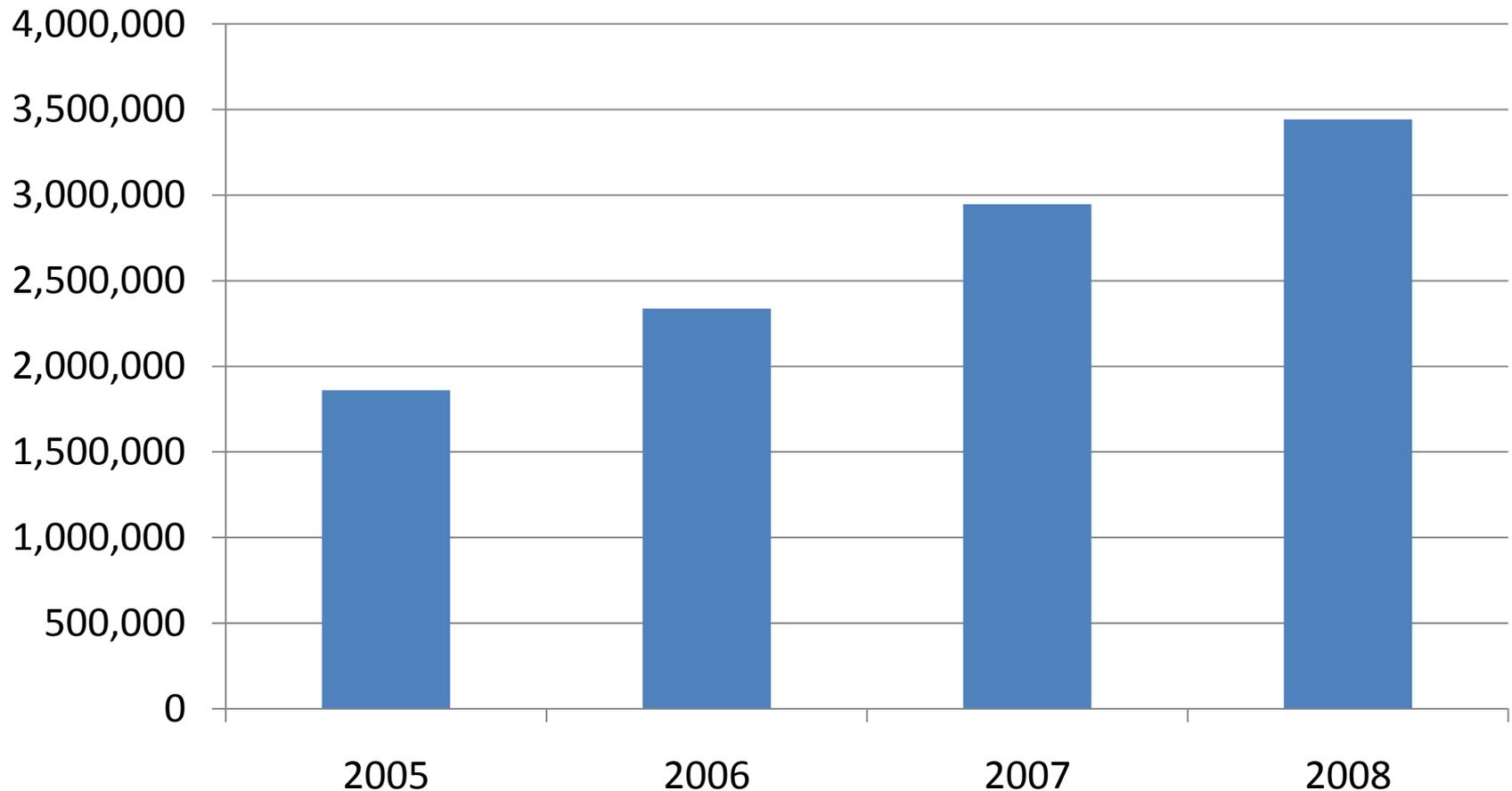


conducted





# Nationally Reported Cases of Malaria



With population of 15 million, this implies underutilization of public sector malaria case management services

# Overview of Partners

- Banque mondiale: Booster program
- Christian Children Fondation Canadienne
- Croix Rouge Canadienne
- Le Fond Mondiale de lutte contre le SIDA, la tuberculose et le paludisme
- Fonds PPTE
- JHPIEGO
- JICA: Japan International Cooperation Agency
- La Coopération Italienne: Projet FRP
- La Coopération Luxembourgeoise: Projet Luxembourg/PSI
- La Coopération Néerlandaise
- Ministère de la Santé du Burkina Faso
- OMS: L'Organisation Mondiale de la Santé
- PLAN Burkina Faso
- PNUD: Programme des Nations Unies pour le développement
- UNICEF
- UNITAID

# Funding Source of Interventions

## Assumptions From Road Map

Intervention	Sources	Amounts	Gaps
ACTS – doses	World Bank (PADS); GFATM 7 & 8	6,856,767	0
RDTs – number	GFATM 7; USAID	2,587,246	522,889
ITNs – number	GFATM 7 & 8; JICA	7,466,134	1,020,866
IPTp – doses	PADS/MOH; CAMEG	1,550,000	15,866
IRS – house- holds	USAID, WHO	25,000	18,000

Global Fund, PADS/World Bank are supposedly focused on the entire country – see comments on assumptions that follow

# Global Fund Information

Round	PR	SR	Dates
2	UNDP	Ministry of Health	2003-05
7	National Council for the Struggle against HIV/AIDS and STI (SP/CNLS-IST)	National Malaria Control Program	2008-13
		PAMAC (an NGO to Support CBOs)	
8	Programme d'appui au developpment sanitaire (PADS)	National Malaria Control Program	2009-14
	PLAN Burkina	Africare, Credo, URCB, RAME	

# Key Findings

- Case Management
- Diagnostics
- ITNs and Vector Control
- Malaria in Pregnancy
- Systems and Organization



**NOUVEAU**

## ARSUCAM

artésunate-amodiaquine

**POSOLOGIE**

1<sup>er</sup> jour 2<sup>e</sup> jour 3<sup>e</sup> jour

1<sup>er</sup> jour 2<sup>e</sup> jour 3<sup>e</sup> jour

1<sup>er</sup> jour 2<sup>e</sup> jour 3<sup>e</sup> jour

La maîtrise du paludisme

sanofi-synthelabo

**Artefan**

pour la douleur et le fièvre

Plus agréable, l'arsuite de

## BUMOL

Suspension

pour la douleur à gout de traite

**INTESTEROL**

appetit

Indications: Convulsions infantiles, Retard de Croissance, Malnutrition sévère.

**MORUOL**

COMPLÉMENT CALCAIQUES

Le calcium est indispensable à la croissance et à la formation des os. MORUOL apporte le calcium nécessaire à la croissance et à la formation des os.

**Xylo-Mepha**

La grande solution d'allergie moderne

**TABLEAU DE CLASSEMENT DES CHIFFRES DE LA S.A.S.**

DATE	Produit	Quantité	Montant
2008			
2009			
2010			
2011			
2012			
2013			
2014			
2015			
2016			
2017			
2018			
2019			
2020			

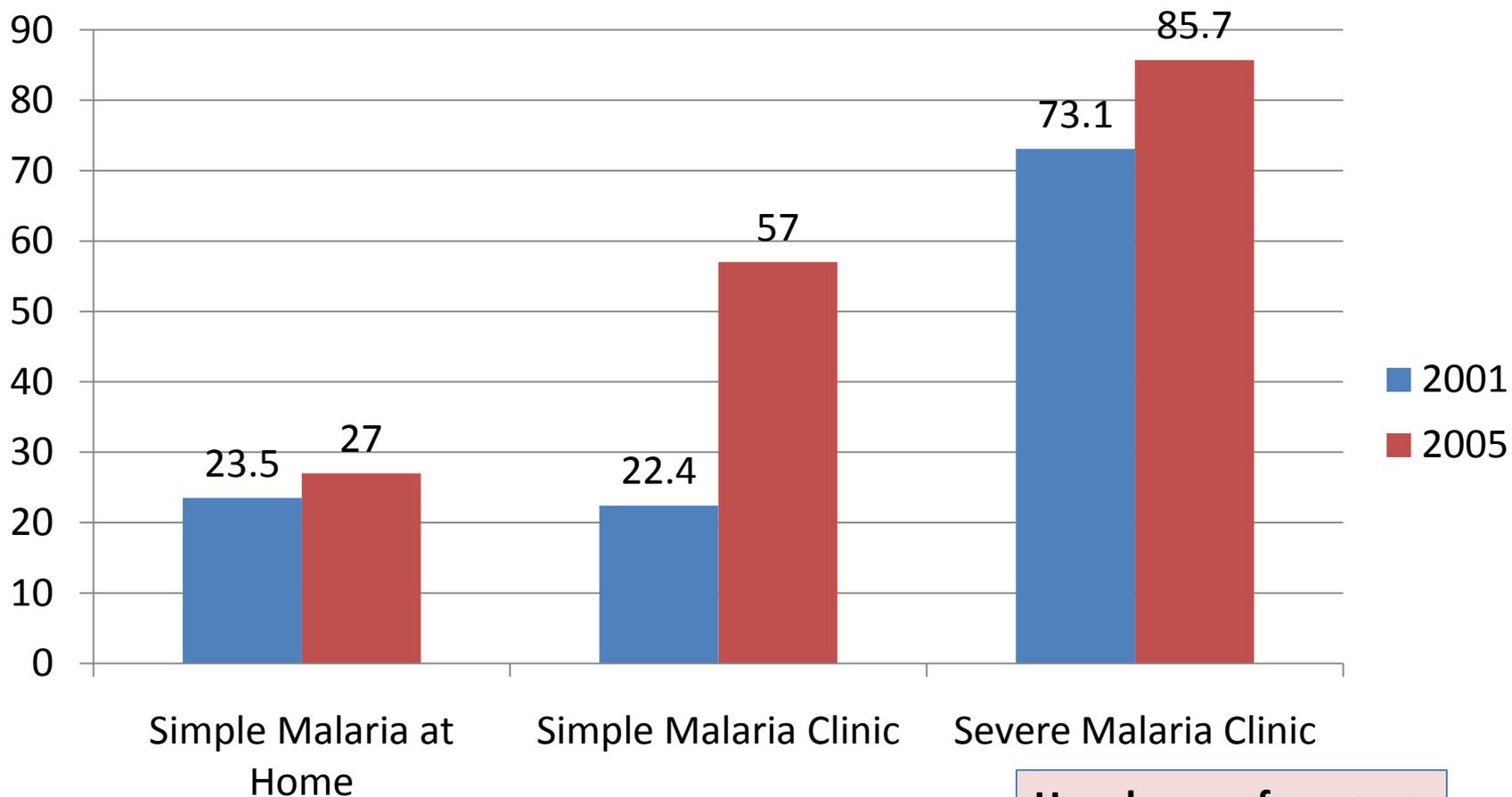
**TABLEAU DE CLASSEMENT DES MOIS DE TOUTE L'ANNÉE**

MOIS	1	2	3	4	5	6	7	8	9	10	11	12
Janvier	10	15	20	25	30	35	40	45	50	55	60	65
Février	10	15	20	25	30	35	40	45	50	55	60	65
Mars	10	15	20	25	30	35	40	45	50	55	60	65
Avril	10	15	20	25	30	35	40	45	50	55	60	65
Mai	10	15	20	25	30	35	40	45	50	55	60	65
Juin	10	15	20	25	30	35	40	45	50	55	60	65
Juillet	10	15	20	25	30	35	40	45	50	55	60	65
Août	10	15	20	25	30	35	40	45	50	55	60	65
Septembre	10	15	20	25	30	35	40	45	50	55	60	65
Octobre	10	15	20	25	30	35	40	45	50	55	60	65
Novembre	10	15	20	25	30	35	40	45	50	55	60	65
Décembre	10	15	20	25	30	35	40	45	50	55	60	65

# **Case Management**

**Including Drug Supply,  
Treatment, Training and Monitoring**

# Correct Case Management Indicators from the Ministry of Health



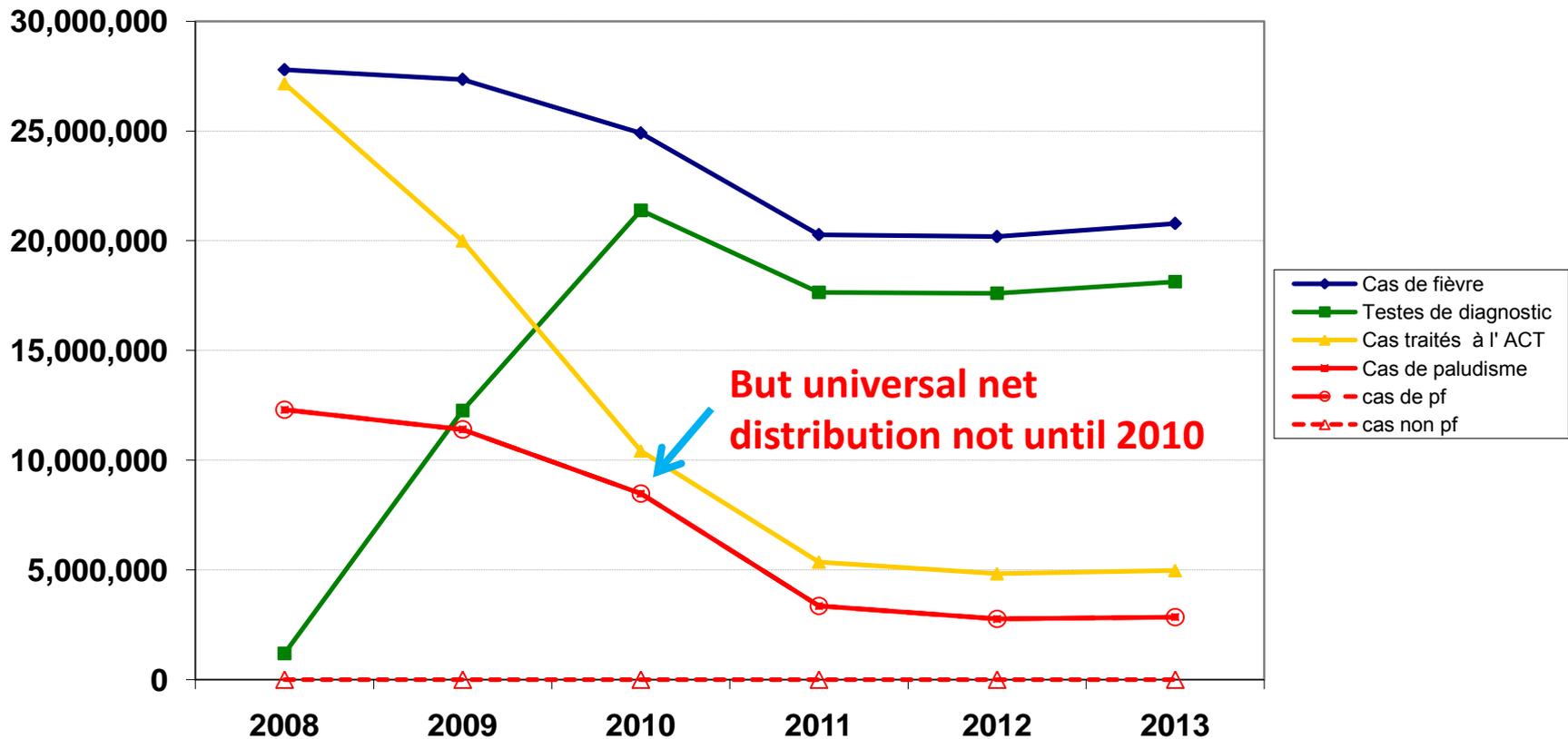
Source: TABLEAU DE BORD DE LA SANTE 2007

How has performance  
changed since ACTs  
introduced?

# Assumptions from 2008 Needs Assessment on ACT Requirements

Population totale à risque de Malaria

Annual Cases



Interestingly, the ITN campaign will not start until July 2010 earliest

# Case Management 2009

- RBM Needs Assessment projects a reduction in cases over time
  - Not sure if projected ACT supply reduction is justified yet given low levels of ITN distribution and use
- Diagnosis not fully implemented, though treatment moving ahead (GFATM R7 Progress Report)
- Community treatment was suspended once chloroquine use stopped, but planned for GFATM Round 8

# Global Fund R8 ACT Estimates Will Lead to Serious Gaps

	2008	2009	2010
Total number of expected cases in the general population (in Health Services and at the community level)	11 046 980	8 795 570	5 564 889
Number of malaria cases expected in health services N	2 966 971	3 343 777	3 141 551
<b>Number of malaria cases expected at the community level (A)</b>	<b>8 080 009</b>	<b>5 451 793</b>	<b>2 423 338</b>

- If ACT supplies using GFATM Round 8 funds follow the projections found in the Grant Proposal there will be severe gaps in treatment because the net campaign will not take place until mid 2010
- Current routine distribution with R7 funds is not adequate to achieve this reduction either

# Acceptance and Adherence Greatly Improved with Co-formulated AA



# Procurement Issues for Treatment

- CAMEG is contracted for ACT procurement
- District orders ACTs based on distribution to health facilities
- Consumption data from facilities is not reaching district pharmacies
- This distribution based system does not allow prediction of need
- Hence some stock-outs



# CAMEG Runs Bamako Initiative Approach to Recover Certain Costs



*Centrale d'Achat des Médicaments  
Essentiels et Génériques*



# GFATM R7 GPR July 2009

## Indicator 1.1 - Number of children under 5 years suffering from uncomplicated malaria and treated with ACT in health facilities according to the national guideline

	Target		Result		0%	30%	60%	90%	100%	
	Period	Value	Period	Value						
Level 3-People reached	4	955,365	4	1,617,856					120%	

## Indicator 1.4 - Percentage of malaria cases confirmed from cases suspected in health facilities (microscopy and RDT)

	Target		Result		0%	30%	60%	90%	100%	
	Period	Value	Period	Value						
Level 3-People reached	4	N: 801,083 D: 1,602,165 P: 50 %	4	N: 143,238 D: 1,602,165 P: 8.9 %					18%	

Child treatment targets are being met, but parasitological diagnosis is lagging

These treatment figures based on previously purchased CAMEG drugs, though GFATM drugs are now in the system since second quarter of 2009

# Explanation of Grant Performance

- Above 100% of the target to treating children under 5 years and persons above 5 years was achieved
- Also over 100% of target achieved for health workers trained and health facilities without stock out of ACT
- Although the performance on these indicators is outstanding, they are not entirely related to the Global fund financing
- ACTs bought under the program are not yet being used since there is a considerable stock of ACTs acquired by CAMEG
- Distribution of RDTs only started in March 2009, having a negative impact on the performance of concerned indicators
- Cases confirmed through microscopy and RDT has only performed at 18%

# Private Sector Treatment

- There are four main wholesalers
- Wholesalers are allowed to buy some products from CAMEG since 2001, but none have yet
- Private pharmacies do buy from CAMEG
- Private pharmacies have ACTs, monotherapies and even sell SP for treatment
- ACT prices can range from CFA 3,500 – 4,000



According to a private pharmacy people used to like Co-Arinate best. Now they prefer Artefan. They don't much like AA products

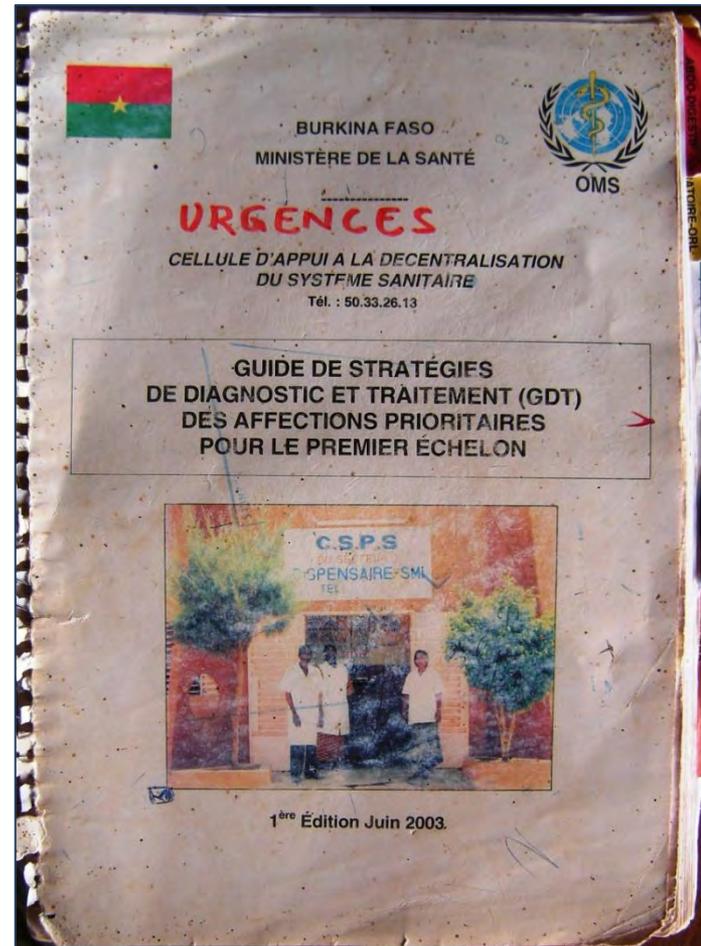
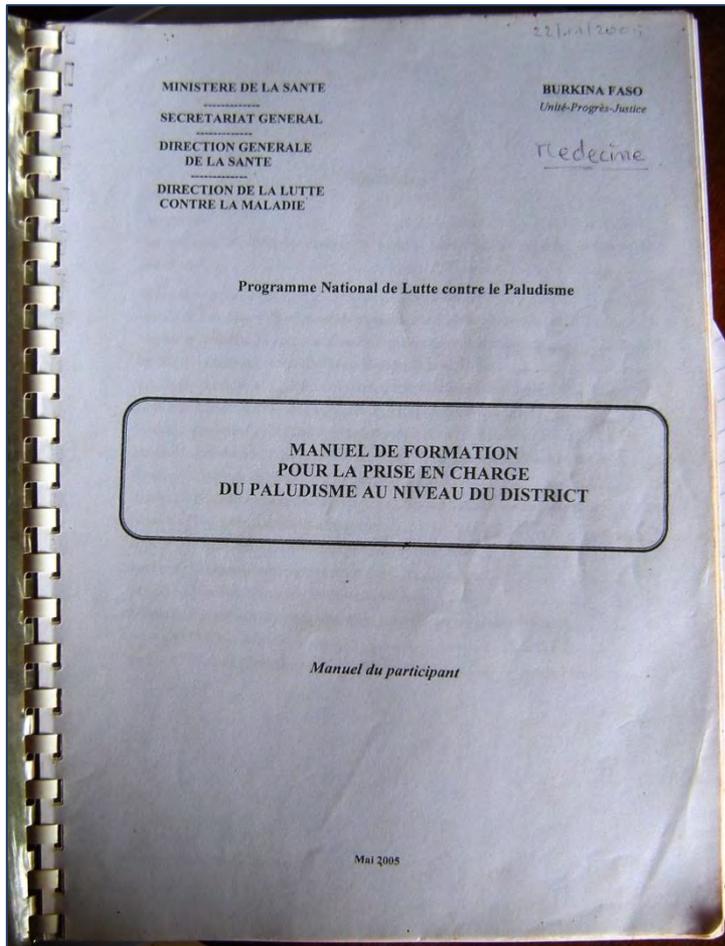
# Private Sector Capacity

- PNLN has trained 475 private clinics in case management guidelines
- Private sector not linked into health information management systems
- PNLN does meet with wholesalers and private providers
- No training for Pharmacies, though their union part of ACT committee under DGPLM

# Case Management Materials in Use at Clinics Visited

- Case Management training materials in use since 2005: mention ACTs and RDTs
- Most treatment providers have been trained with these, and health workers keep copies of the manuals given at training
- There is also a comprehensive treatment manual for all diseases in use that was published in 2003, thus mentions chloroquine

# 2005 Malaria Case Management and 2003 Overall Disease Treatment Guide

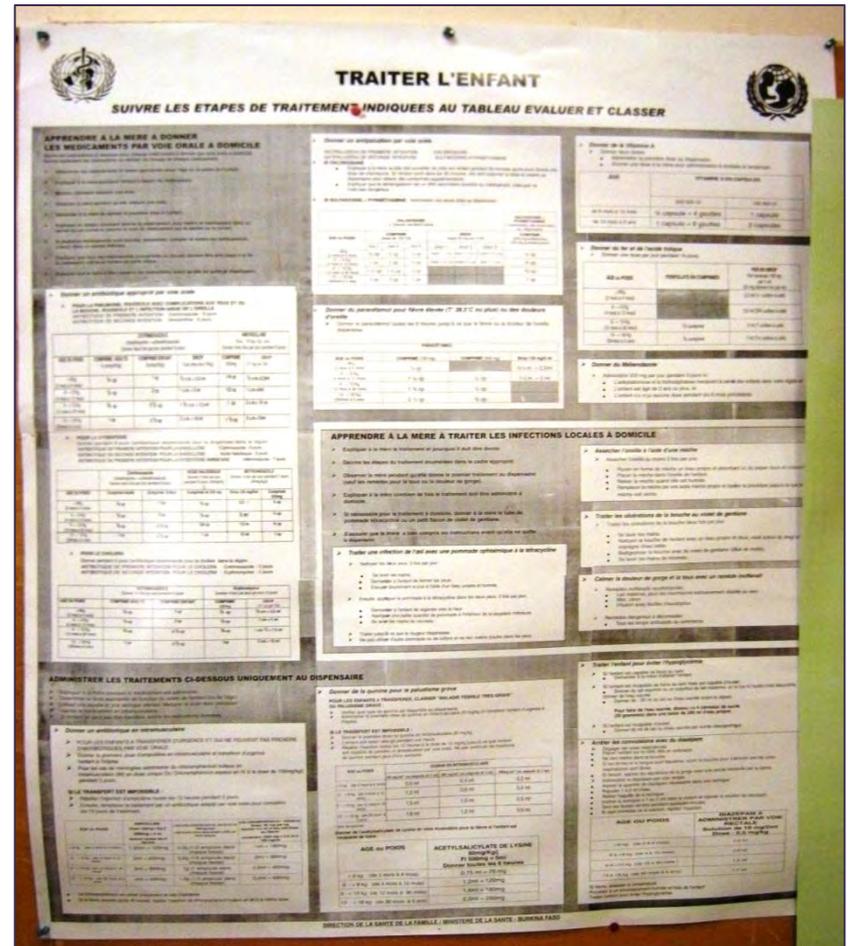
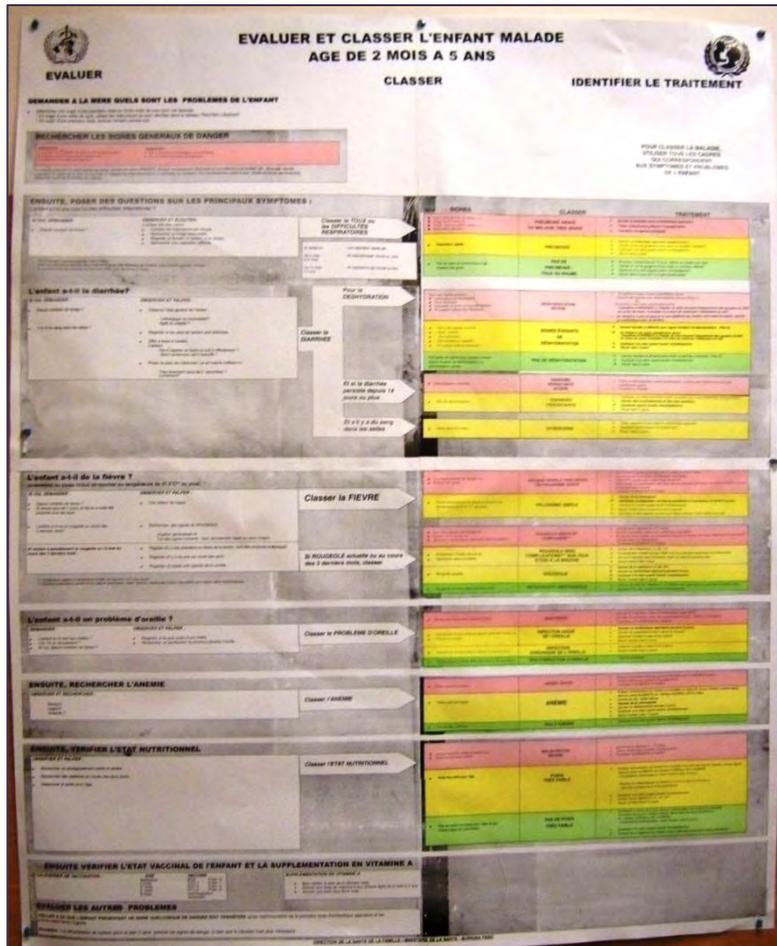


Electronic copy of revised case management manual for 2007 exists 32

# Directorate of Family Health

- IMCI training materials are available
- These also address the newborn child
- There are aids to guide the health worker and mother on child development milestones
- These materials have been updated in April 2009 and adapted with help from UNICEF and WHO
- There are record forms included

# IMCI Job Aids Available at DSF and Regional Hospital but not at front line Clinics



# Home Made Job Aids for ACT Use

RESOLUTION DE L'ASSOCIATION (Pec PALU SIMPLE)  
ARTESUNATE + AMBIDIAQUINE

POSOLOGIE	J <sub>1</sub>		J <sub>2</sub>		J <sub>3</sub>	
	ARTESUNATE	AMBIDIAQUINE	ARTESUNATE	AMBIDIAQUINE	ARTESUNATE	AMBIDIAQUINE
< 10 Kg (2-4 an)	1/2 CP	1/2 CP	1/2 CP	1/2 CP	1/2 CP	1/2 CP
10 à 20 Kg (4-7 ans)	1/2 CP x 2	1/2 CP x 2	1/2 CP x 2	1/2 CP x 2	1/2 CP x 2	1/2 CP x 2
21 à 40 Kg (7 à 13 ans)	1 CP x 2	1 CP x 2	1 CP x 2	1 CP x 2	1 CP x 2	1 CP x 2
> 40 Kg (> 13 ans)	2 CP x 2	2 CP x 2	2 CP x 2	2 CP x 2	2 CP x 2	2 CP x 2

QUANTITE DE SANG A TRANSFUSER (Q<sub>T</sub>)

Q<sub>T</sub> = (Tx atteindre - Tx actuel) x Pds x 7

7 = INDICE

SYNAGRAMME DE TRAITEMENT DU PALUDISME GRAVE PAR LES SELS DE QUININE CHEZ L'ENFANT

Dose de charge	Maintien voie veineuse	Dose d'entretien	Maintien voie veineuse
Quinine en perf (avec SGI) 20mg/kg	Perfusion de SGI	Quinine en perf avec du SGI 10mg/kg	Perfusion de SGI
H <sub>0</sub> en 4 heures	H <sub>4</sub> pendant 8 heures	H <sub>12</sub> en 4 heures	H <sub>16</sub> pendant 8 heures H <sub>24</sub>

POSOLOGIE QUININE RESERCHINE

Q<sub>T</sub> = (Tx atteindre - Tx actuel) x Pds x 7  
 Q<sub>T</sub> = (Tx atteindre - Tx actuel) x Pds x 7

POSOLOGIE DU COARTESIENE SIROP (ARTEMETHER + LUMEFANTRINE)

POIDS DE L'ENFANT	NOMBRE de JOUR d'antibio		
	J <sub>1</sub>	J <sub>2</sub>	J <sub>3</sub>
5 Kg	7 mL	7 mL	7 mL
7.5 Kg	10 mL	10 mL	10 mL
10 Kg	14 mL	14 mL	14 mL
15 Kg	20 mL	20 mL	20 mL

ARTEMETHER + LUMEFANTRINE CP

POIDS (AGE)	JOUR 1	JOUR 2	JOUR 3
5 à 9 Kg (2-4 an)	1 CP x 2	1 CP	1 CP
10 à 14 Kg (4-6 an)	1 CP x 2	1 CP x 2	1 CP x 2
15 à 24 Kg (6-8 an)	2 CP x 2	2 CP x 2	2 CP x 2
25 à 34 Kg (8-12 an)	3 CP x 2	3 CP x 2	3 CP x 2
≥ 35 Kg (≥ 12 ans)	4 CP x 2	4 CP x 2	4 CP x 2

QUININE 300 mg CP

10 mg/kg toutes les 8 heures  
 (utiliser en relais après un ttt de quinine par VV)

POSOLOGIE DE QUELQUES PRODUITS COURAMMENT UTILISES

1- AMPICILLINE INJECTABLE

- ENFANTS ET NOURISSONS  
 Voie IM = 50 mg/kg/24H en deux injections, matin et soir  
 Voie IV = 100 à 300 mg/kg/24H  
 - Nouveau Né  
 Voie IV = 100 à 300 mg/kg/24H  
 NB Us HCS = 200 mg/kg/24 heures

2- Ceftriaxone inj

- Enfant et nourissons:  
 M.C.S = 70 à 100 mg/kg/jour en 1 ou 2 inj IV (avec 1/2 d'interval)  
 - Nouveau Né  
 50 mg/kg/jour en une injection  
 que l'on voit l'indication  
 3- VACCINE  
 - < 6 ans = 1 mg/kg/1sr 50 à 10 g/kg/1sr  
 - 6 à 12 ans = 7.5 à 15 mg/kg/1sr (7.5 à 150 g/kg/1sr)

# But New Job Aids Can Be Found on the Wall at the Ministry of Health

**TRAITEMENT DU PALUDISME SIMPLE**  
**Fièvre: ATTENTION!** Traiter d'abord le paludisme  
**MEDICAMENTS AU CHOIX**

**COMBINAISON FIXE**  
 ARTEMETHER (20mg) + LUMEFANTRINE (120mg)

**COMBINAISON FIXE**  
 ARTESUNATE (ART) + AMODIAQUINE (AQ)

**COMBINAISON SEPARÉE**  
 ARTESUNATE (ART) 50mg + AMODIAQUINE (AQ) 153 mg

Pour cette combinaison, la dose journalière est administrée en prise unique.  
 Pour cette combinaison, la posologie est de 4mg/kg/jour pour ARTESUNATE, et de 10mg/kg/jour pour AMODIAQUINE.

POIDS & AGE	1 <sup>er</sup> JOUR		2 <sup>ème</sup> JOUR		3 <sup>ème</sup> JOUR	
	ART	AQ	ART	AQ	ART	AQ
	Matin	Soir	Matin	Soir	Matin	Soir
Moins de 10kg Moins d'un an	☐	☐	☐	☐	☐	☐
10 à 20 kg 1 - 7 ans	☐	☐	☐	☐	☐	☐
21 à 40 kg 7 - 13 ans	☐	☐	☐	☐	☐	☐
Plus de 40kg Plus de 13 ans	☐	☐	☐	☐	☐	☐

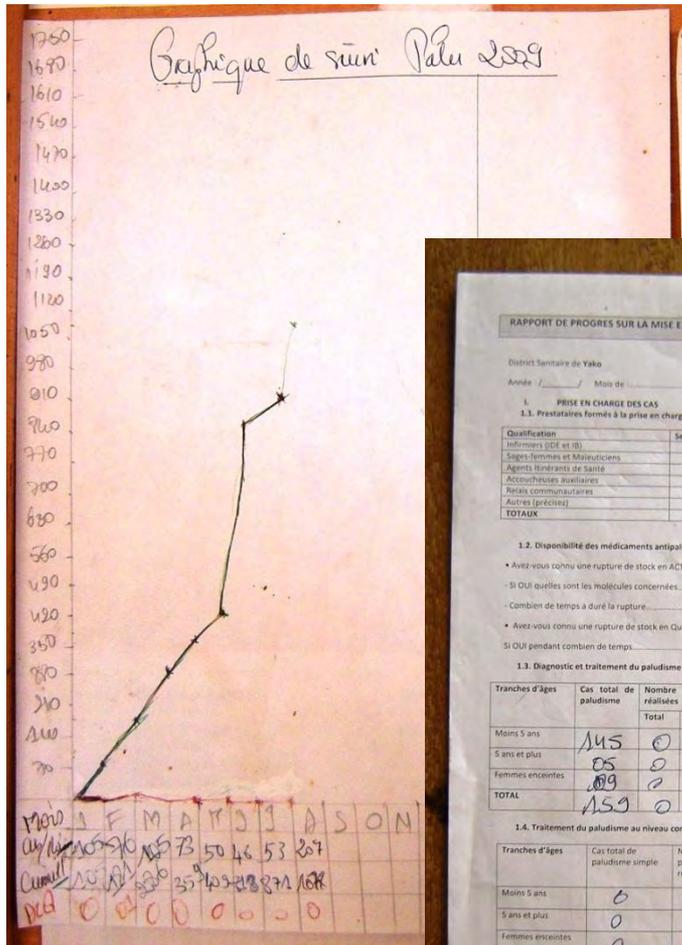
**Pour une guérison rapide, respectons les doses prescrites et la durée du traitement.**

**PREVENTION DU PALUDISME**  
chez la femme

MINISTRE DE LA SANTE - BURKINA FASO

This Job Aid Stresses Presumptive Treatment First

# Tracking Case Management



NOM ET PRÉNOMS DU PATIENT	PROFESSION	SEXE	AGE	VILLAGE OU LIEU DE PROVENANCE DU MALADE		SIGNES/ SYMPTÔMES DOMINANTS	DIAGNOSTIC	TRAITEMENT	OBSERVATIONS	ANCIEN- NÉ
				NOM DU VILLAGE	Distance en km					
306	Wama Aziz	M	35	Sanja	3-4	fièvre, frissons, courbatures	PS	Amoxiclav + ACP	15/11/09	
307	Bamaga Audrey	F	30	Samba	3-4	fièvre, frissons, courbatures	PS	Paracétamol	15/11/09	
308	Cher Lamine	M	30	Samba	3-4	fièvre, frissons, courbatures	PS	Amoxiclav + ACP	15/11/09	
309	Bamaga Josephine	F	30	Samba	3-4	fièvre, frissons, courbatures	PS	Paracétamol	15/11/09	

**RAPPORT DE PROGRES SUR LA MISE EN ŒUVRE DES ACTIVITES DE LUTTE CONTRE LE PALUDISME**

District Sanitaire de Yaka      CPSP de \_\_\_\_\_

Année / \_\_\_\_\_ Mois de \_\_\_\_\_

**1. PRISE EN CHARGE DES CAS**

1.1. Prestataires formés à la prise en charge du paludisme dans le trimestre

Qualification	Secteur Public	Secteur Privé	Totaux
Infirmiers (DE et IB)			
Sages-femmes et Maïeuticiens			
Agents hiérarchiques de santé			
Accoucheuses traditionnelles			
Relais communautaires			
Autres (préciser)			
<b>TOTAUX</b>			

1.2. Disponibilité des médicaments antipaludiques et consommables

- Avez-vous connu une rupture de stock en ACT
- Si OUI quelles sont les molécules concernées: \_\_\_\_\_
- Combien de temps a duré la rupture: \_\_\_\_\_
- Avez-vous connu une rupture de stock en Quinine
- Si OUI pendant combien de temps: \_\_\_\_\_

1.3. Diagnostic et traitement du paludisme au niveau des formations sanitaires

Tranches d'âges	Cas total de paludisme	Nombre de GE réalisés		Nombre de TDR réalisés		Nombre de cas ayant bénéficié d'un traitement par les ACT
		Total	Positif	Total	Positif	
Moins 5 ans	115	0	0	0	0	115
5 ans et plus	05	0	0	0	0	05
Femmes enceintes	09	0	0	0	0	0
<b>TOTAL</b>	<b>129</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>120</b>

1.4. Traitement du paludisme au niveau communautaire

Tranches d'âges	Cas total de paludisme simple	Nombre de cas de paludisme graves référés	Nombre de cas de paludisme simple ayant bénéficié d'un traitement par les ACT
Moins 5 ans	0	0	0
5 ans et plus	0	0	0
Femmes enceintes	0	0	0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>

At Petit Samba staff graphed malaria cases. Their treatment register shows PS – simple malaria treated with AA and paracetamol. An incomplete summary form was found inside the treatment register

# Sample Summary Form from a Health Facility in Ouahigouya District

## 1.3. Diagnostic et traitement du paludisme au niveau des formations sanitaires

Tranches Ages	Cas total de paludisme		Nombre de TDR réalisés		Nombre de cas ayant bénéficié d'un traitement par les ACT
	PS	PG	Total	Positif	
Moins 5 ans	423	16			439
5 ans et plus*	233	15	43	37	268
Femmes enceintes	35	01	32	31	
<b>TOTAL</b>	<b>691</b>	<b>32</b>	<b>75</b>	<b>68</b>	<b>687</b>

\*Les PE ne sont pas comprises

Indications are that RDTs do not define treatment choices and that pregnant women may not be getting ACTs

# ACT Stock Management is also Monitored on Summary Forms

V. GESTION DES MEDICAMENTS DE LUTTE CONTRE LE PALUDISME						
Médicaments		Quantité totale reçue dans le trimestre	Quantité totale distribuée dans le trimestre	Quantité totale restante en fin de trimestre	Besoins à commander	Observations
ACT Amodiaquine + Ariésunate	Nourrisson (2-11 mois)	200	198	02	152	
	Petit enfant (1-5 ans)	200	150	50	100	
	Grand enfant (6-13 ans)	200	150	05	100	
	Adulte (14 ans et plus)	50	45	05	100	
Quinine injectable 400mg		180	100	08	100	
Quinine injectable 200 mg		96	84	12	96	
Quinine sulfate 300mg		4000	3000	1000	2000	
SP pour TPI SP (Sulfadoxine Pyriméthamine) TPI (Traitement Préventif Intermittent du palu chez la femme enceinte)		710	300	410	00	
TDR (Test de Diagnostic Rapide)		75	75	00	100	

# Paying for Case Management



Medicine	CFA	USD
ACT Syrup for Children	950	2.23
ACT Tablets for Child	100	0.24
ACT Tablets for Adult	300	0.70
Paracetamol for Child	150	0.35

When medicines are channeled through CAMEG there is recovery of distribution costs

# Case Management Challenges

- Community prefer new co-formulated ACTs
- But there are still complaints that ACTs (AA) make one weak – affecting adherence
- Health workers complain of patients presenting ‘late’
  - Preference for local herbs cited by health staff
  - Many cases referred to hospital need transfusions but blood difficult to find
  - In private pharmacies people demand AA less

# Treating Severe Malaria



- Usually involves referral to District Hospital
- Supplies of Quinine available
- Malaria said to be main cause for admission
- Challenge comes when blood transfusion needed
- Hypoglycemia is another challenge

# Severe Malaria Provisions

- Currently no provision for management of Severe Malaria in GFATM Round 7 or 8 proposals
- CAMEG stocks of quinine from 2008 still available at district hospitals
  - First day free
  - Charges for subsequent two days
- USAID plans to provide approximately
  - 150,000 treatment kits for the management of severe malaria
  - Training for 1,260 new health workers in the treatment of uncomplicated and severe malaria

# Community Case Management

Ministère de la Santé



BURKINA FASO  
Unité - Progrès - Justice



**MODULE DE FORMATION DES AGENTS DE SANTÉ COMMUNAUTAIRES IMPLIQUÉS DANS LA LUTTE CONTRE LE PALUDISME AU BURKINA FASO**

Manuel du participant



Edon Juin 2009

- Community Health Agent role in case management was put on hold when ACTs start
- PNLP has developed new training guidelines
  1. General Malaria
  2. Malaria Prevention
  3. Case Management
  4. Mobilization

# Community Agents Will Soon Be Trained in Case Management



Poids (age)	Présentations	Jour 1	Jour 2	Jour 3
 4,5 à 9 kg (2 -11 mois)	Artésunate 25 mg Amodiaquine 67,5 mg	⊖	⊖	⊖
 9 à 18 kg (1 -5 ans)	Artésunate 50 mg Amodiaquine 135 mg	⊖	⊖	⊖
 18 à 36 kg (6 -13ans)	Artésunate 100 mg Amodiaquine 270 mg	⊖	⊖	⊖
 >36 kg (+14 ans)	Artésunate 100 mg Amodiaquine 270 mg	⊖ ⊖	⊖ ⊖	⊖ ⊖

Severe malaria should be referred to the health facility

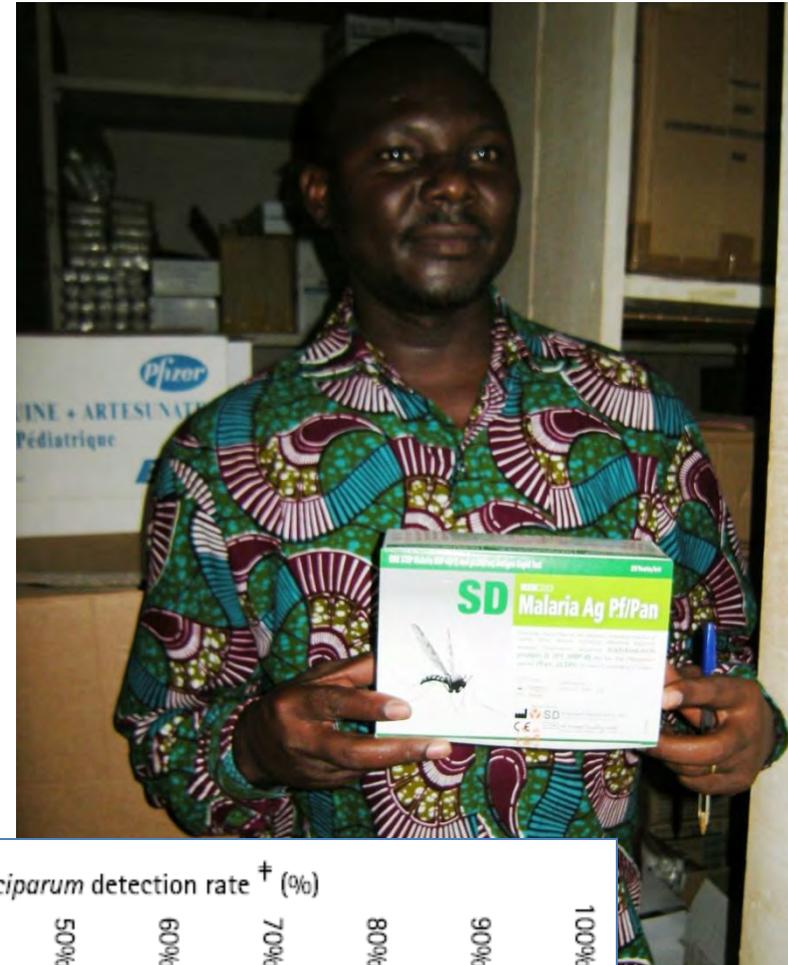
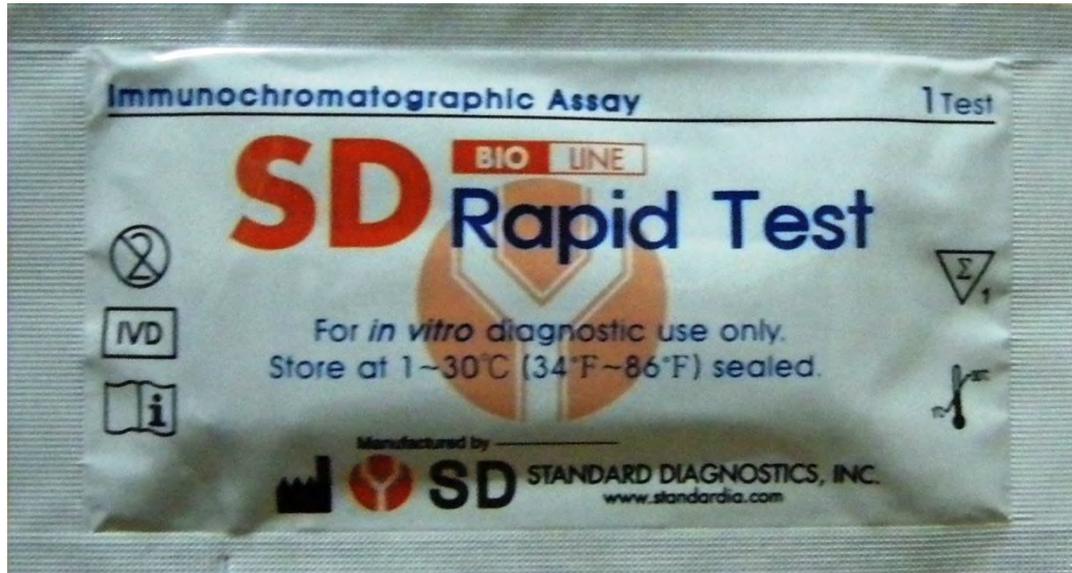
# Community in Global Fund Round 8

- Objective 2: Provide **home treatment** with ACTs for at least 80% of simple malaria cases seen at community level, in line with national treatment policy, by 2013
  - Indicator 2.1: Number of community agents trained in treating simple malaria with ACTs in line with national directives
  - Indicator 2.2: Number of cases of simple malaria treated with ACTs by community agents, in line with national directives
- There are problems in quantification as seen earlier in terms of premature assumed reductions in cases/ACTs
- Also what are provisions for RDTs at community level?

# **Diagnostics**

## **Laboratories and Rapid Tests**

# RDTs in use



# TOT for RDTs – August 2008

## Conducted by National Laboratories



# RDTs as Part of Case Definition in National Treatment Directives

## I. DEFINITION DE CAS

### ***a) Le cas de paludisme présomptif.***

Au Burkina Faso, le paludisme doit être évoqué devant **toute fièvre** :

- température axillaire de 37°5 ou plus
- corps chaud ou antécédent de corps chaud **dans les 72 dernières heures**

### ***b) Le cas de paludisme confirmé***

Le paludisme est confirmé par :

- La mise en évidence du plasmodium à l'examen microscopique par goutte épaisse/frottis sanguin
- ou la positivité du Test de Diagnostic Rapide (TDR)

# Six pilot regions for RDT now

- 25/51 Facilities in Yako District trained this year and Ouahigouya all 55
- Donor support primarily from GFATM R7
- Training consisted of orienting the head of the health facility who in turn was to orient his/her staff
- National Lab involved, did training of trainers
- No job aids or guidelines, just packet insert

# RDT Challenges

- District Hospital Lab Staff are involved in supervision and monitoring
- Hospitals have Lab Staff shortages thus not likely available for RDT supervision
- No quality control system in place
- At PHC facility problem of health worker 'culture' trusting clinical judgment most
- No evidence that pilot is being tracked and evaluated
- Longer term question of community case management and RDTs

# Guidelines for RDT

- Aside from any guidance for RDT use in the six pilot regions there are no specific RDT guidelines available
- The national directives for malaria case management mention RDTs twice as one of the ways by which simple malaria can be recognized in addition to fever and other signs and symptoms

**Generic instruction for malaria rapid test cassette. *P. falciparum* only**

**1** FIRST, read carefully these instructions.

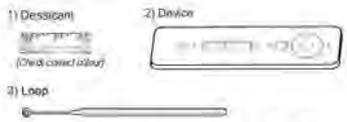
**2** Collect:

- 1) alcohol
- 2) cotton
- 3) gloves
- 4) lancet
- 5) buffer
- 6) timer

**3** Look at the expiry date at the back of the package.  
Use another package if expiry date has passed.



**4** Open the package and look for the following:



**5** Write patient's name at the back of the device.



**6** Clean the patient's finger with alcohol. The finger MUST be dry before pricking.



**7** Prick the patient's finger to get a drop of blood.

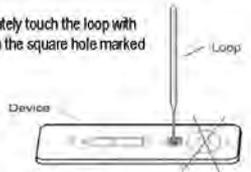


**8** Touch the loop to the blood.

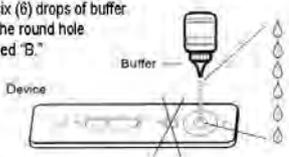


Version 2: Modify for specific product

**9** Immediately touch the loop with blood on the square hole marked "A."



**10** Put six (6) drops of buffer into the round hole marked "B."



**11** Read results exactly fifteen (15) minutes after adding buffer.

Do not read the results before fifteen (15) minutes. Reading too early or too late can give false results.



**12 HOW TO READ:**

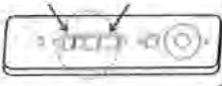
**NEGATIVE** (no falciparum malaria) - one line in window "C" at left.



**POSITIVE** falciparum malaria - one line in window "C" at left and one line in window "T" at right.



It is positive even if test line is faint.

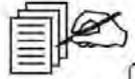


**NO RESULT** - no line in "C" or "T."



If the control line does NOT appear, any other lines should be disregarded. The test should be repeated!

**13** Record results.



**14** Dispose of infectious waste properly.



Use new package and lancet for each patient.

Generic WHO Job Aid may have been used during TOT but not seen in clinics

# RDT Distribution

- CAMEG both procured and distributed first procurement of Round 7 (2008)
- The next procurement is to be through the Directorate of Pharmacy and Medical Laboratories – a regulatory agency
- CAMEG role not clear in second RDT procurement, though more experienced
- Need to explore more about RDTs in private sector

# RDT Storage

- SD requires 1-30 degree temperature range
- Regional CAMEG did not have RDT, but general store room very hot
- In Yako, district store has air conditioning 24 hours 7 days a week
- Clinics keep RDTs in the consultation rooms – no electricity



# Hospital Labs Mainly for Internal Use



- Overworked staff
- Inadequate supervision
- Little feedback
- Poor quality control
- No real in-service training
- Not involved in RDT supervision at health facilities – but too many facilities even if they did

# National Lab would like to do more supervision and monitoring



# **Long Lasting Insecticide-Treated Nets and Vector Control**

**Policies, Programs and the Path to  
Universal Coverage**

# LLINs

- Nets have previously been provided to 'vulnerable' groups during routine ANC and child health services
- There has been a shortage of nets recently and provision has been focused more on children <1 year of age
- Routine record forms do not appear to have unique places to record net provision; informally written on cards
- Private sales of nets are common in Ouagadougou



# Current Routine Distribution Processes for Nets

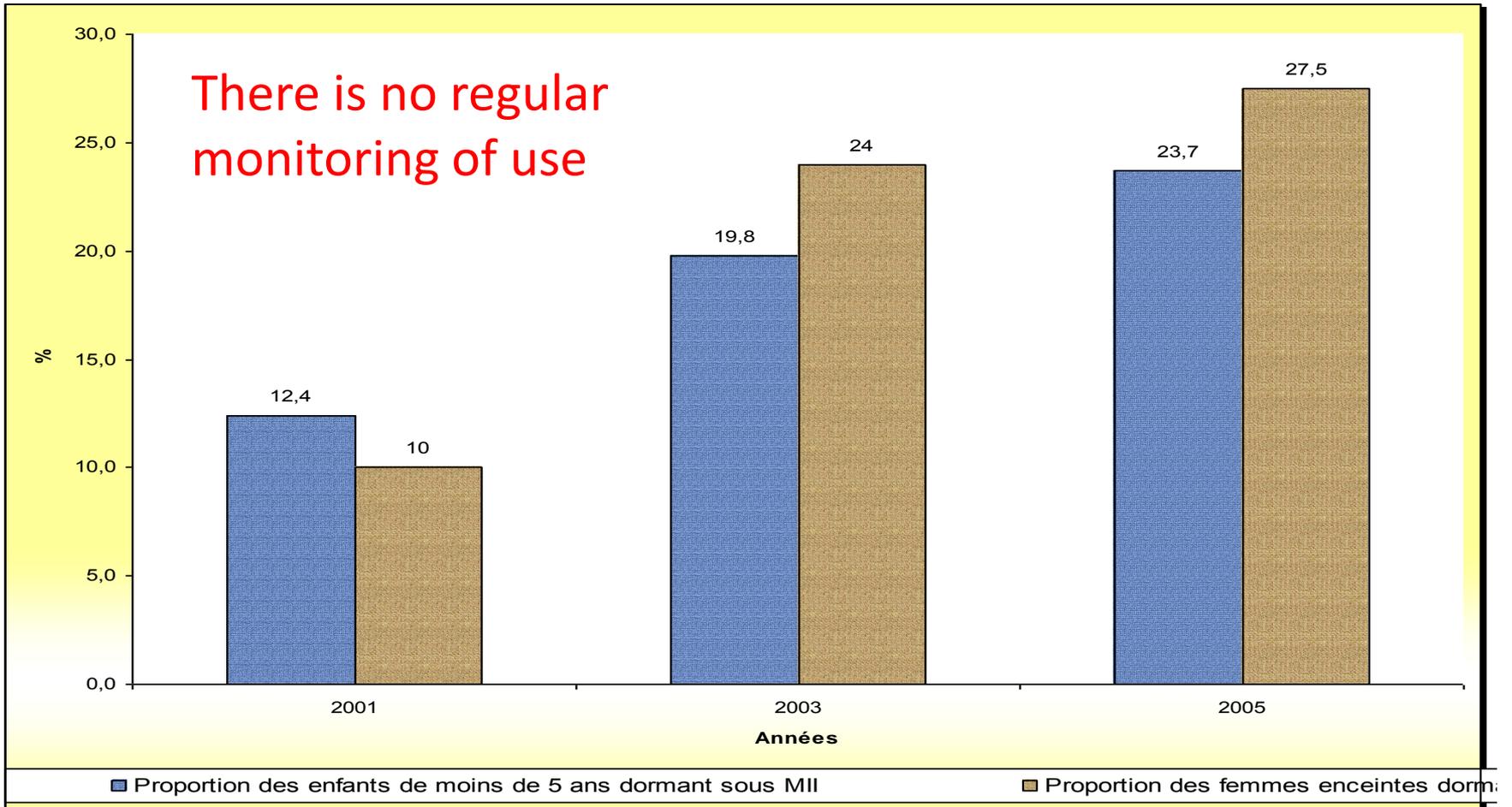
- Nets are sent to front line facilities for pregnant women and children based on population estimates
- With PADS or GF money, PNLP contracts private transporters to deliver nets from PNLP directly to each district
- Then districts also contract local transporters to deliver to the health facilities

# Currently Nets, When Available, Are Free for Vulnerable Groups at Clinic



- Stocks arrive from time to time
- Maybe one tranche is designated for children <5 or children <1 year
- Another tranche might be designated for pregnant women
- No consistency in routine distribution – confuses providers and clients

# ITN Use Reported in Road Map



# Health Worker Observations

- People may not hang nets ...
  - due to house construction difficult to tie nets (may attempt to hang temporarily if health workers come to inspect)
  - Sleep on mats – not sure how to use nets
  - when also use bedroom for cooking – fear fire hazard
  - If feel nets reduce breeze, ventilation
- Training needed in net promotion for all levels

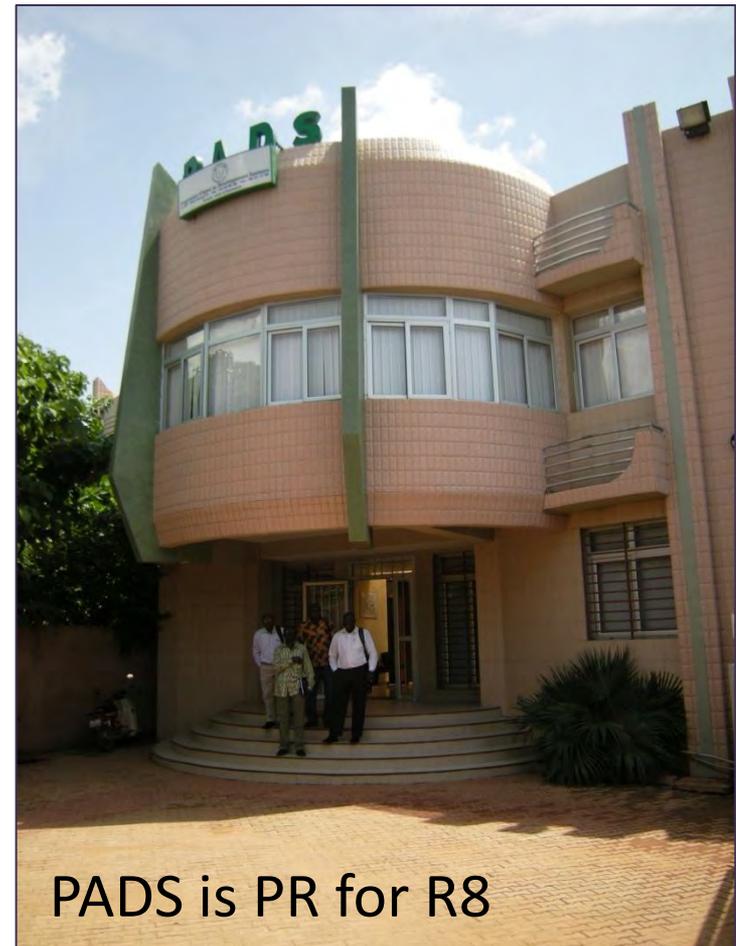
# ITN Progress from Round 7 GFATM

Objective 2	Increase the use of ITN by people at risk for malaria in particular pregnant women and children less than 5 years old								
SDA	Prevention: Insecticide-treated nets (ITNs)								
Indicator 2.1 - Number of ITN distributed (excluding distribution to pregnant women)									
	Target		Result						
	Period	Value	Period	Value	0%	30%	60%	90%	100%
Level 0-Process/Activity Indicator	4	1,901,463	4	564,923					30%
Indicator 2.2 - Number of ITN distributed to pregnant women									
	Target		Result						
	Period	Value	Period	Value	0%	30%	60%	90%	100%
Level 0-Process/Activity Indicator	4	512,537	4	276,359					54%

**Global Fund Comment:** Although bednets arrived in November 2008, the PR was late in signing the contracts for distribution to the sites what contributed to the late distribution of bednets. The PR was recommended to accelerate LLNs distribution and a plan was conceived for this purpose considering most of the LLNs have to be distributed during the rainy season (May, June and July).

# Both Round 7 and 8 Have LLINs

- In Round 7, which is currently undergoing Phase 2 application, there should be 600,000 nets per year for routine distribution
- The nets in Round 8 are for the campaigns to achieve universal coverage with 6.6 million LLINs



# Research on Net Use

- Decreased motivation in the use of insecticide-treated nets in a malaria endemic area in Burkina Faso
  - Lea Pare Toe *et al.*, *Malaria Journal* 2009
- PermaNet 2.0<sup>®</sup> and Olyset<sup>®</sup> were distributed in 455 compounds at the beginning of the rainy season
- Soumousso is a typical Guinean savannah village situated about 55 km east from Bobo-Dioulasso
- *Anopheles gambiae* (M and S form), *Anopheles funestus* and *Anopheles nili*, are found in this village

# The motivation to use bednets decreased after < 1 year

- Inhabitants' **conception of malaria and the inconvenience** of using bednets in small houses were the major reasons
- Acceptance was moderated by the fact that mosquitoes seen as **not only cause** of malaria
- Use of ITNs adversely affected by **functional organization** of the houses: changed as between day and night
- Bednets not used when perceived benefits of reduction in mosquito nuisance and of malaria were considered not to be worth the **inconvenience** of daily use

# Research on Costs of Social Marketing vs. Free ANC Distribution 2006-7

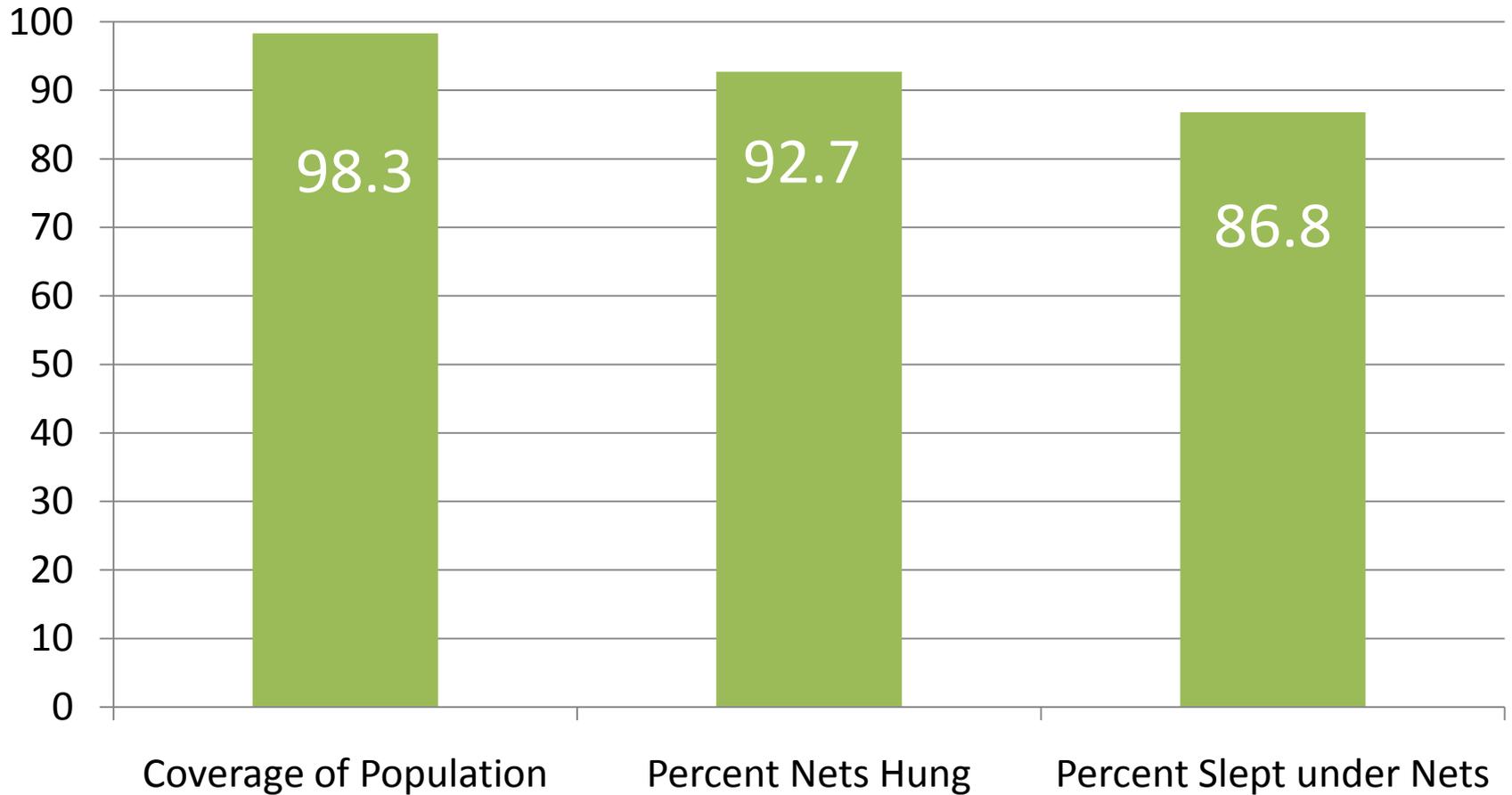
- Financial Costs
  - US\$8.08 for socially marketed nets
  - US\$7.21 for free nets in ANC
- Due to the district's ability to rely fully on the use of existing resources, financial costs associated with free ITN distribution through ANC were in fact even lower than those associated with the social marketing campaign
  - De Allegri *et al.* 2009 – Health Policy and Planning



# Plan for Coverage in Pilot

<b>Population of Diébougou in 2008</b>	<b>102,165</b>
Number of Nets Planned for Distribution	60,000
Number of Distribution Sites	161
Number of volunteers for mobilization, distribution and follow-up	336
Number of Supervisors	32
Households that Obtained LLIN	23,927
Population of Households	120,965
Number Actually Distributed	67,313

# Pilot Campaign Results



**Follow-up was only one week after pilot campaign**

# Pilot Net Challenges

- Difficulty understanding the definition of "household" by volunteers
- Budget inadequate for planning especially at district level
- Census data underestimated the actual need
- Hard to access population working on farms
- Rainy season transportation problems
- Inadequate social mobilization

# Field Supervision for Campaign

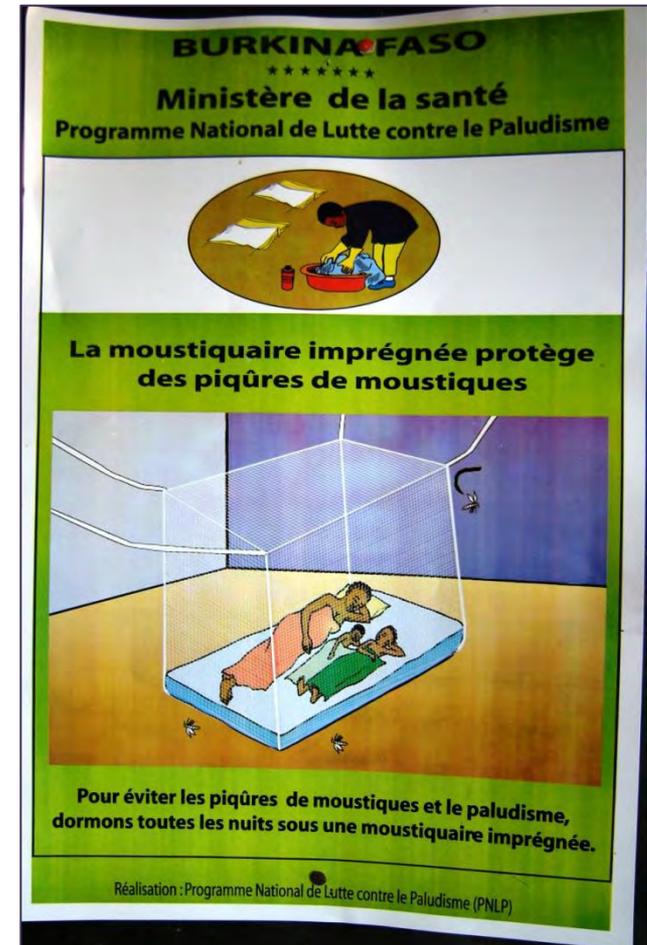
- During the pilot there were four field teams responsible for supervising some of the 20+ Health Facilities and surrounding communities
- Teams consisted of at least two Ministry representatives (e.g. PNLP, Regional, District) and at least one NGO (e.g. Red Cross, Plan, Credo)
- By implication there may need to be over 300 such teams to supervise the national distribution among the 1700 primary health facilities

# Is Burkina Faso Ready for More?

- 6.6 million LLINs from Global Fund to be distributed in July 2010
- Need better ...
  - Budget planning and mobilization of resources
  - harmonization from national → regional → provincial → community levels
  - Census estimates
  - Orientation and supervision of staff at all levels
  - Mobilization for access, hanging and use

# New BCC Materials Have Been Produced Though not Yet Disseminated

- These materials may not address community concerns
- The Round 8 PR (PADS) is planning to contract local NGOs and CBOs for community education around the upcoming campaign
- Their approaches must be standardized, coordinated and culturally sensitive



# Universal vs. Routine

- The national malaria strategy (2006-10) primarily addresses routine distribution of ITNs to vulnerable groups in clinics
- The upcoming campaign is aiming at universal coverage, though there is a gap of 1.4 million nets to meet goal of 2 per household
- Going forward, there needs to be recognition of both catch-up through the campaign and keep-up through routine supply and distribution

# LLIN Procurement and Distribution for Universal Coverage

- PADS is PR for public sector for R8
  - **63,203,438** Euros
- Responsible for procurement of nets (not CAMEG)
- Is imbedded within the MOH and management common basket funds from partners (created in 2003 to support the national health development plan)
- Has a procurement unit
- Procurement plan approved by LFA/GF

# The first partnership consideration of campaign planning

- Before 13 October 2009, only Round 8 PR and SRs had considered the steps for the campaign from their individual perspectives (see next slide)
- At meeting on 13<sup>th</sup> other partners saw the outline timetable for the first time
- Partners thus finally began to discuss the campaign seriously
  - Present: PNLP, Deliver, MCHIP, Africare, URCB, Plan, Credo, RAME, Lutheran World Relief

# Campaign Distribution Steps

- Mise en place des comites d'organisation de la campagne
- Planification des activites de la campagne
- Elaborations des outils
- Formation des acteurs
- Sensibilisation et de mobilisation sociale
- Recensement des menages
- Approvisionnement en MILDA
- Entreposage et securite des MILDA
- Distribution des MILDA
- Suivi de l'utilisation des MILDA dans les menages
- Evaluation de la campagne

# IRS Today

- No IRS in recent years
- NMCP's five-year strategy proposes IRS in 30 health zones with higher levels of transmission (e.g. in southwest)
- NMCP anti-vector strategy also includes
  - larviciding and
  - environmental management
  - these two activities are not currently taking place.

# IRS Planned

- Main partners are USAID for a pilot phase in 25,000 households
- This may take place in early-mid 2010
- Coordination in timing with universal LLIN campaigns needed
- WHO for technical assistance for longer term planning
- IRS strategy meeting currently taking place

# Community Agents Will be Trained in Prevention through Vector Measures



- Environmental Management
- Mosquito net use
- ITN re-treatment (?)
- ***Campaign role planned***



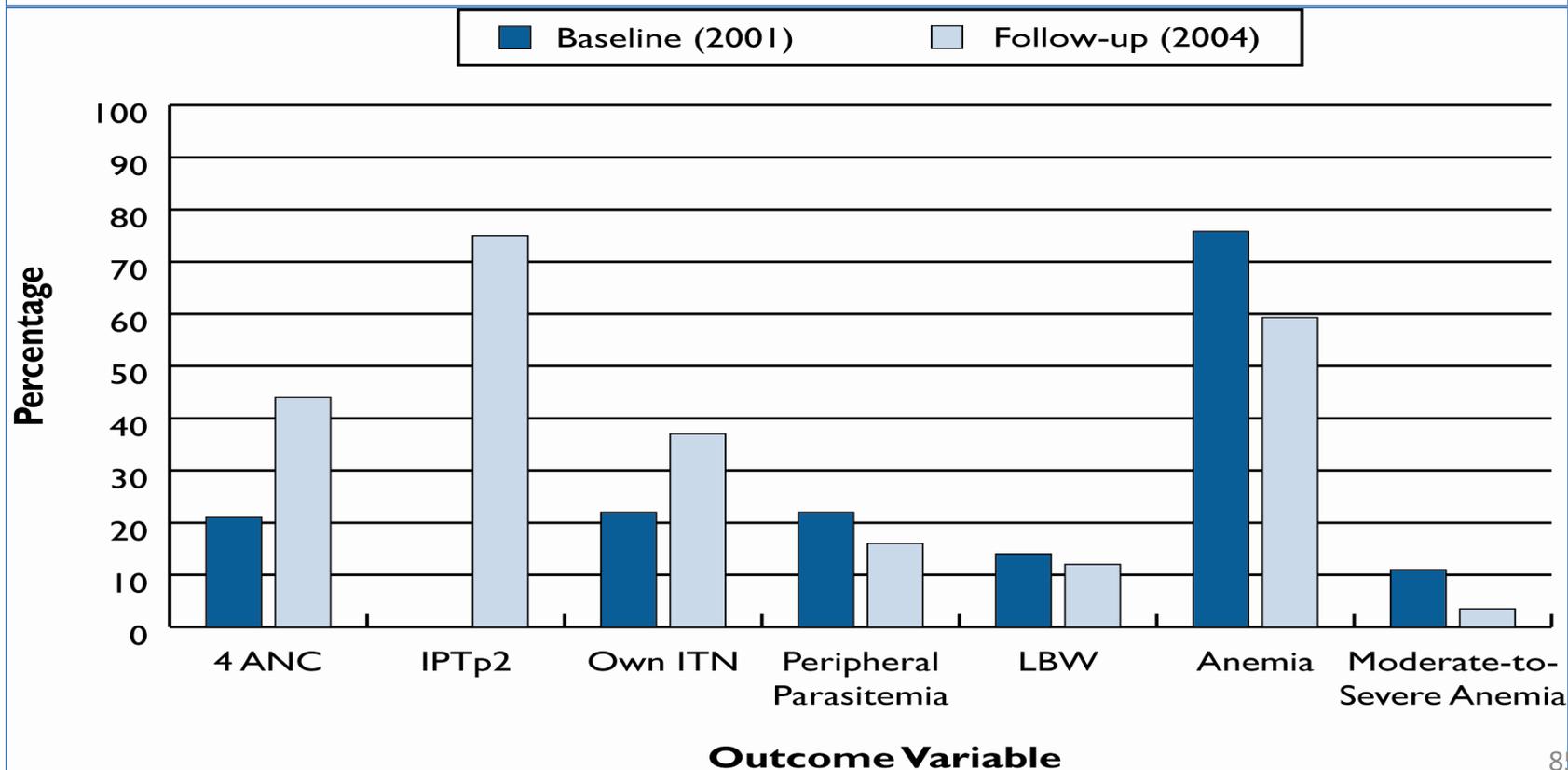
# **Malaria in Pregnancy**

**Policy, Components, Supplies,  
Monitoring and Training**

## MALARIA PREVENTION DURING PREGNANCY: ASSESSING THE DISEASE BURDEN ONE YEAR AFTER IMPLEMENTING A PROGRAM OF INTERMITTENT PREVENTIVE TREATMENT IN KOUPÉLA DISTRICT, BURKINA FASO

SODIOMON B. SIRIMA, ANNETH H. COTTE,\* AMADOU KONATÉ, ALLISYN C. MORAN, KWAME ASAMOA, EDITH C. BOUGOUMA, AMIDOU DIARRA, ALPHONSE OUÉDRAOGO, MONICA E. PARISE, AND ROBERT D. NEWMAN\*

*Centre National de Recherche et de Formation sur le Paludisme, Ministère de la Santé, Ouagadougou, Burkina Faso; Malaria Branch, Division of Parasitic Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention, Atlanta, Georgia; Maternal and Neonatal Health Program, JHPIEGO Corporation, Baltimore, Maryland*



# IPTp Guidance



- IPTp: national policy since 2004
- The 2003 guide to treatment of diseases at the primary level recommends chloroquine prophylaxis
- IPTp with SP is now included in Case Management Directives (rev 2007)
- This IPTp job aid developed by Access-Jhpiego is still available in some facilities

# National Strategy 2006-2010

## Addresses IPTp

- *Prévention du paludisme pendant la grossesse:* en plus de l'utilisation des moustiquaires imprégnées par les femmes enceintes, il a été adopté dans les directives techniques nationales la promotion du Traitement Préventif Intermittent (TPI) avec la Sulfadoxine-Pyriméthamine comme stratégie de prévention du paludisme pendant la grossesse. Il est appliqué à raison de 2 cures supervisées de 3 comprimés de Sulfadoxine 500 mg et Pyriméthamine 25 mg, avec un intervalle d'au moins un mois, entre le 4<sup>ème</sup> et le 8<sup>ème</sup> mois de la grossesse.

MICS 2006 reports only 1.6% of pregnant women received at least two doses of SP for IPTp

# MIP Mentioned in National Case Management Directives (2007)

## VI. PREVENTION DU PALUDISME PENDANT LA GROSSESSE

- La prévention du paludisme chez la femme enceinte est une priorité. Elle est basée sur le Traitement Préventif Intermittent (TPI) et l'utilisation des Moustiquaires imprégnées d'insecticides.

### **6.1. Traitement Préventif Intermittent**

- Le médicament recommandé est **la Sulfadoxine Pyriméthamine** et le schéma préconisé est le suivant : Le TPI débute au deuxième trimestre. Il consiste à administrer **3 comprimés** de SP en **une prise orale** au **deuxième trimestre** et au **troisième trimestre**. (respecter l'intervalle d'au moins un mois entre les prises et ne pas administrer au dernier mois).
- La prise de la SP sera supervisée au niveau de la formation sanitaire par un agent qualifié.

### **6.2. Utilisation des Moustiquaires imprégnées d'insecticides**

- En plus du TPI, il est fortement recommandé aux femmes enceintes de dormir sous MII pendant toute la grossesse.

# Pharmacy Company Job Aid Stresses SP for IPTp

La réponse rapide aux cas de paludisme résistant

## Maloxine

Hydrochlorure de pyriméthamine

Apparition des mouvements actifs du fœtus

Vitesse de la croissance fœtale

TRAITEMENT 1

TRAITEMENT 2

TRAITEMENT 3

Conception

5

10

15

20

25

30

35

Naissance

SEMAINES DE GESTATION  
(Paludisme pendant la grossesse)

### Traitement préventif intermittent (T.P.I.)

### Prévention du paludisme chez la femme enceinte

**Indications**

**Contre-indications**

**Mode d'administration**

**Posologie**

**Effets indésirables**

**Précautions d'emploi**

**Autres informations**

**Remarque de traitement préventif intermittent**

**Précautions**

8 4:17AM

# SP Supplies Readily Available on Desk an ANC in Pelegtenga



# SP Availability

- In the public sector SP is only ordered for ANC clinics and not found in the general pharmacy
- Private Pharmacies still sell SP generally
- This packet of Maloxine cost 500 CFA, about 1/8<sup>th</sup> the cost of ACTs



# What is Free

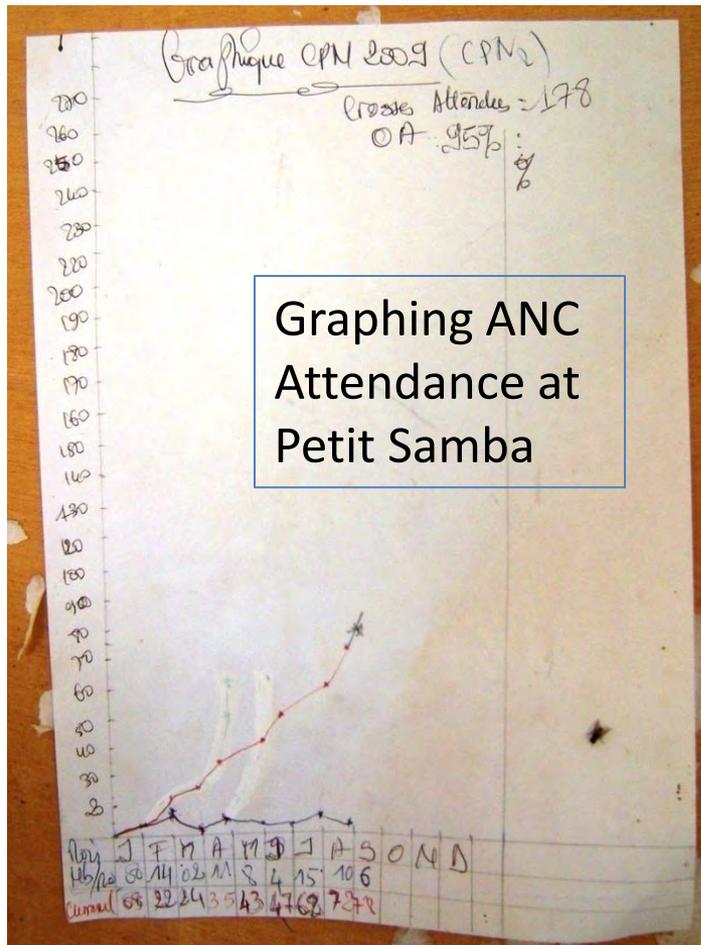
- Ideally ANC is supposed to be free
- Some supplies of SP are free (MOH/PADS)
- Some come through CAMEG and attract a charge
- Some clinics have both
- Distribution of free SP through Directorate Family Health



# Managing SP Supplies

- First dose is free for the pregnant women attending the ANC, but pregnant women pay for subsequent doses
  - *explaining probably the low use rate for the subsequent doses*
- Quantity procured for free distribution through ANC is not enough to cover all the doses for the pregnant women attending ANC
- DSF has estimated 650 million CFA as a budget required to cover the total needs in SP, but the PNLB cut the budget

# ANC Attendance



- MIP interventions traditionally built on ANC platform
- Good first attendance
- Problem with fewer subsequent visits
- Thus difficult to give at least two doses of IPTp



# IPTp Record Keeping is a Mystery: SP Listed only Once on ANC Card

ANTÉCÉDENTS OBSTÉTRICAUX ET FACTEURS DE RISQUE					EXAMENS DE LABORATOIRE		
GESTATION : 6	PARITÉ :	Enfants vivants: 01 Enfants décédés: 0	AVORTEMENTS : 0		DATE	EXAMENS	RESULTATS
Avortements à répétition	<input type="checkbox"/>	**			26/09/09	Sérologie VIH	Négatif
Hypertension + oedèmes + albuminurie	<input type="checkbox"/>	***					
Césarienne	<input type="checkbox"/>	****					
Hémorragie du post - partum	<input type="checkbox"/>	*					
Mort-né au dernier accouchement	<input type="checkbox"/>	**					
Primiparité > 30 ans	<input type="checkbox"/>	*					
Multiparité > 8	<input type="checkbox"/>	*					
Grossesse gémellaire	<input type="checkbox"/>	*					
Drépanocytose ou diabète	<input type="checkbox"/>	**					
Maladie cardio-respiratoire	<input type="checkbox"/>	**					
CONDUITE A TENIR : * Accouchement au CM Obligatoire ** A référer au médecin *** A référer immédiatement à l'hôpital **** Accouchement dans un centre chirurgical obligatoire							
EXAMENS PERIODIQUES					TRAITEMENT		
DATE	26/09/09	17/10/09	21/10/09	25/09/09	CONDUITE A TENIR	DATE	
Poids	54 kg	55 kg	54 kg	-	Boiteuse = *	SP Fer + AP	
Taille	1m 41	-	< 152 cm = *	-	Boiteuse = *		
T.A.	10/6	10/5	-	-	> 14/9 = **		
Oedèmes	néant	0	0	défect	Positif = **		
Albuminurie	traces	-	-	-	Positif = **		
Anémie	act	act	act	act	Grave = *		
GS Rh	-	-	-	-			
Varices	néant	0	0	néant			
H.U.	23	24mm	25mm	25mm			
B.D.C.	+	+	+	+			
Paroi abdominale	souple	souple	souple	souple			
T.V.	cent	cent	cent	cent			
Présentation	CA	CA	CA	CA	Siège = *		
Promontoire		maxi	maxi		Transverse = ****		
Electrophorèse hb							

# Register also lists SP only once no matter how many ANC Visits

	15/01	Nom & Prenom	date	CPN	taille	poids	TA	Observ	conj	vacu	minut	#U	Prédict	BDC	TV	observa	Anciens CPN
109		Qued Adile 26ans 2 <sup>e</sup> gèle Togo Saidu Bogou	8/9/9	I	1m65	57	915	○	est	+++			20m NPF	+	CCLFDP	MAI SP FAP	recher
110		Kissou Carine 20 ans II gèle Libouré Martin Bogou	8/9/9	I	1m63	60kg	1217	○	est	○			20m CM	+	CCLFDP	MAI SP FAP	recher
111		Bamogo Simone 43 ans 7 <sup>e</sup> gèle 2 del 14ds Kouakou Antoine Koboko	8/9/9	I	1m56	45kg	916	○	est	○			26m CM	+	CCLFDP	MAI SP FAP	recher
112		Kissou Taliano 19 ans I <sup>e</sup> gèle Qued Maxime Bogou	8/9/9	I	1m53	55kg	1015	○	est	○			24m Siege?	+	CCLFDP	MAI SP FAP	recher
113		Nananda Rosale 19 ans II gèle Quedroya Souley Tangara	8/9/9	I	1m47	42kg		○	est	○			15m NPF	BF	CCLFDP	MAI SP FAP	recher
114		Qued Chantal 27 ans III gèle Kissou J. Baptiste Ziguindé	8/9/9	I	1m63	62kg	915	○	est	○			23 CM	+	CCLFDP	MAI SP FAP	

# Even in client booklet the preventive medicine is written only once

**Gestation** *IV - DCCU 5 Mvorteng*

Dernières règles le : .....

Accouchement prévu le: .....

Examens Périodiques : .....

Examens	1er Examen	2è Examen	3ème Examen	4ème Examen
Date	<i>12/10/06</i>	<i>17/11/06</i>	<i>11/12/06</i>	
Taille	<i>155</i>			
Poids	<i>46 kg</i>	<i>57</i>	<i>46</i>	
T.A	<i>116</i>	<i>106</i>	<i>815</i>	
Œdèmes	<i>neant</i>	<i>neant</i>	<i>neant</i>	
Anémie	<i>Col</i>	<i>Col</i>	<i>Col</i>	
Urines				
Hauteur Uterine	<i>25</i>	<i>28cm</i>	<i>28</i>	
Présent	<i>siège</i>	<i>CR</i>	<i>CR</i>	
Bruit du cœur	<i>+</i>	<i>+</i>	<i>+</i>	
TV	<i>cccl</i>	<i>cccl</i>	<i>cccl</i>	
Promontoria	<i>sp</i>			
Varices	<i>neant</i>	<i>neant</i>	<i>neant</i>	
Vergétures	<i>neant</i>	<i>neant</i>		
Dentition	<i>12 DS</i>	<i>12 DS</i>	<i>12 DS</i>	
Seins				

*RDX = 12/10/06 17/11/06 11/12/06*

**Prévention** *S - S - 3*

Paludisme: *chloro 1000*

Anémie: *Fe + B P 100/2*

Vaccinations: .....

	DATE
VAT 1	<i>12/10/06</i>
VAT 2	<i>13/11/06</i>
VAT 3	
VAT 4	
VAT 5	

Antitétanique

Autres: .....

**Examens Complémentaires**

Date	Nature de l'examen	Résultats

Although still using CQ in 2006, this booklet shows how malaria prevention not listed each time it was given

# Summary Form Distinguishes IPTp 1 and 2

**II. PREVENTION**

**2.1. Traitement Préventif Intermittent (TPI) pendant la grossesse**

- Nombre de grossesses attendues dans le CSPS : 1 295 1
- Nombre de femmes enceintes inscrites en CPN 1 : 1 100 1
- Nombre de femmes enceintes inscrites en CPN 2 : 1 92 1
- Nombre de femmes enceintes ayant reçu le TPI 1 : 135 136 126 1
- Nombre de femmes enceintes ayant reçu le TPI 2 : 149 124 124 1

**2.2. Distribution des Moustiquaires Imprégnées d'Insecticides (MII)**

Nombre de MII distribuées aux moins de 5 ans	Nombre de MII distribuées aux Femmes Enceintes	Nombre de MII distribuées aux autres groupes (hors cibles)	Total de MII distr
<u>38</u>	<u>61</u>	<u>00</u>	<u>99</u>

- Clinic records do not distinguish the number of times each woman received SP for IPTp
- Summary forms sent from clinics provide data for IPTp 1 and 2
- No explanation can be found for how health staff determine these data
- No IPTp data were found in Ministry's 2008 annual statistical report

# Training for MIP



- Currently there is no distinct training for MIP
- Both treatment and IPTp are covered under the National Directives for Case Management
- The Directorate for Family Health has generic FANC slides and hopes to strengthen MIP component

# Only One Slide Addresses MIP

## Education sanitaire : Thèmes abordés

- La prévention du paludisme :
  - Traitement préventif intermittent (TPI)
  - Utilisation des moustiquaires imprégnées d'insecticide (MII) et autres méthodes
- Questions importantes de discussions :
  - La nutrition
  - Pratiques traditionnelles, produit
  - L'utilisation de produits potentiellement nocifs
  - L'hygiène
  - Le repos et l'activité

# Community Health Agents for MIP

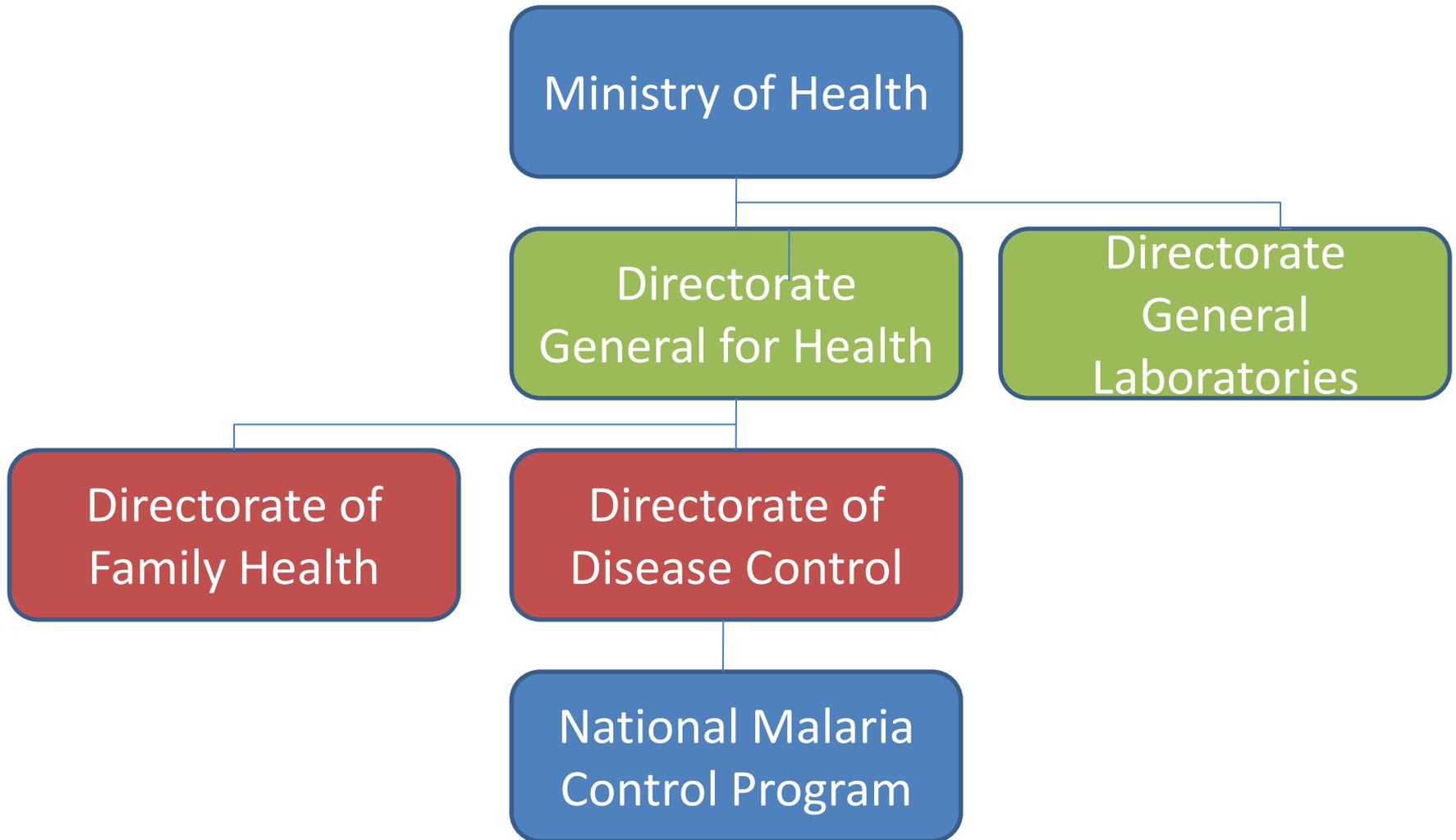


- Agents should encourage pregnant women to accept IPTp
- They are made aware that pregnant women should sleep under nets
- They should refer pregnant women with suspected malaria immediately
- Staff occasionally ask agents to trace a woman who misses an ANC appointment

# **Systems and Organizational Issues**

**Strengths, Partnerships, M&E,  
Community**

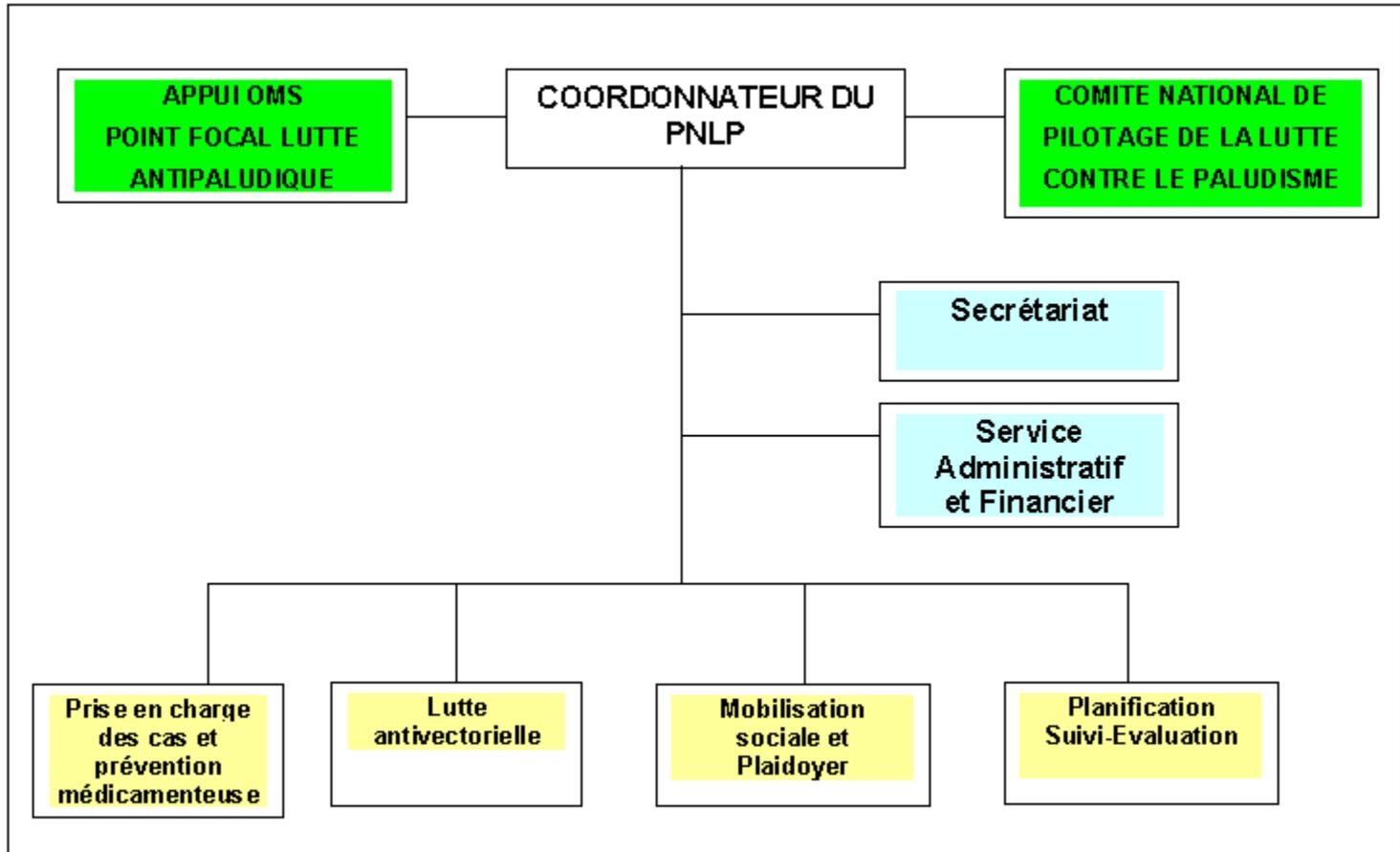
# Where is the PNLP?



# PNLP Strengths and Challenges

- Eighteen total staff at present
- Recruitment of officers planned with GF Round 8 including
  - communicator, accountant, pharmacist logistician, medical doctor, malaria program officer at PAMAC
- Challenges of relationships with other program departments and units – e.g. CAMEG, DSF, DEP, DGISS, DGPML, etc.

# Organigramme of PNL



# PNLP Staffing Establishment

Emplois	Effectif		Besoin
	2008	2009	2010
Médecins	4	3	5
Pharmaciens	1	1	1
Conseiller de santé (Nurse)	1	1	1
Attaché de santé (Spécialisé Nurse)	6	6	6
Communicateur	1	1	1
Techniciens du génie sanitaire (Sanitarian)	1	1	1
Gestionnaires des Hôpitaux	2	2	2
Comptable	1	1	1
Secrétaire	1	2	2
<b>TOTAL</b>	<b>18</b>	<b>18</b>	<b>20</b>

# Malaria Implementing Staff

- Key implementing staff are based with the Directorate for Family Health and located at district level and below
- In district team there would be one person responsible broadly for disease control, but not positioned to supervise front line malaria service delivery
- MCH person on district team may not have specific malaria responsibilities either

# Budget Support for PNLP

Sources de financement	Année 2 (2008)		
	Budget	%	Expended
OMS	93 557 937	92%	86 324 937
UNICEF	16 343 169	100%	16 343 169
PADS	24 328 980	100%	24 328 980
Budget National	2 068 900	100%	2 068 900
FM (GFATM)	406 699 676	95%	388 096138
<b>A rechercher</b>	<b>443 809 000</b>		
<b>TOTAL</b>	<b>542998662</b>		<b>517162124</b>

# Partnership Environment

- PNLN hosts a quarterly RBM National Steering Committee including, for example ...
  - WHO – PADS (World Bank) – Red Cross
  - UNICEF – CAMEG – Directorate Family Health
  - Plan – Africare – CNLS – JICA – Jhpiego
  - DGPML – CNRFP – Jeremi Dijon – DLM
- There are also semi-annual technical committee meetings

# Partnership Reviews Malaria Action Plans on Quarterly Basis

- During quarterly meetings PNLN sets agenda, leads meeting
- Mostly a quarterly review of the PNLN annual plan implementation
- Partners then share their activities that are not directly with PNLN – e.g. work with certain districts
- Other events and news shared
- Enlist partners in upcoming events – e.g. GFATM grant writing, or partners offer support
- Partners talk freely and when needed, critically

# Pre-Service Training

PROFILS / FORMATIONS	CRITERES				
	DIPLOME EXIGES	DUREE DE LA FORMATION	COUT / AN NATIONALS	COUT / AN ETRANGERS	LIEU DE FORMATION
Garçons et Filles de salle	C.E.P.E. Ou équivalent	9 mois	251 714 Frs	377 571 Frs	Tenkodogo
Agents Itinérants de santé	Certificat d'Etudes Primaires Elémentaires (C.E.P.E.) ou équivalent	2 ans	251 714 Frs	377 571 Frs	Bobo-Dioulasso Koudougou Ouahigouya
Accoucheuses Auxiliaires	Brevet d'Etudes du Premier Cycle (B.E.P.C.) ou équivalent	2 ans	251 714 Frs	377 571 Frs	Koudougou Fada N'gourma Tenkodogo
Infirmiers/ ères Brevetés	B.E.P.C. ou équivalent + Attestation de la Classe de Terminale	3 ans	251 714 Frs	377 571 Frs	Ouagadougou Bobo-Dioulasso Ouahigouya
Accoucheuses Brevétées	B.E.P.C. Ou équivalent + Attestation de la Classe de Terminale	3 ans	251 714 Frs	377 571 Frs	Ouagadougou Bobo-Dioulasso
Infirmiers/ ères d'Etat	BAC	3 ans	700 649 Frs	1 050 973 Frs	Ouagadougou
Sages-Femmes	BAC	3 ans	700 649 Frs	1 050 973 Frs	Ouagadougou
Maïeuticiens d'Etat	BAC	3 ans	700 649 Frs	1 050 973 Frs	Ouagadougou
Préparateurs d'Etat en Pharmacie	BAC	3 ans	700 649 Frs	1 050 973 Frs	Ouagadougou
Manipulateurs d'Etat en Electro-Radiologie Médicale	BAC	3 ans	700 649 Frs	1 050 973 Frs	Ouagadougou
Technologistes Biomédicaux	BAC	3 ans	700 649 Frs	1 050 973 Frs	Ouagadougou
Techniciens d'Etat du Génie Sanitaire	BAC	3 ans	700 649 Frs	1 050 973 Frs	Ouagadougou
Gestionnaires des Hôpitaux	BAC	2 ans	399 795 Frs	599 692 Frs	Ouagadougou
Adjoints des Cadres Hospitaliers	B.E.P.C. ou équivalent	2 ans	251 714 Frs	377 571 Frs	Ouagadougou
Administrateurs des Hôpitaux et Services de Santé	Maîtrise ou License ou équivalent	3 ans	799 795 Frs	1 199 693 Frs	Ouagadougou

- National School of Public Health trains staff who work in districts and front line facilities
- The School readily admits that its curricula need to be updated concerning malaria issues

Basic Courses Offered for Various Levels of Front Line Health Worker

# Basic Nurses, Midwives Curriculum

- Malaria is addressed only under the objective “acquire competency in the case management of medical pathologies”
  - One of several dozen possible diseases included in the course
  - No mention of MIP
  - For each disease the tutor should ideally cover all aspects seen at the right →
1. Definition
  2. Rappel anatomo-physiologique
  3. Generalites
  4. Physiopathologie
  5. Manifestations cliniques
  6. Moyens d’investigation
  7. Conduite therapeutique
    - traitements medicaux
    - soins infirmiers
  8. Ordigramme
  9. Moyens de prevention

MINISTÈRE DE LA SANTÉ  
 SECRETARIAT GÉNÉRAL  
 DIRECTION GÉNÉRALE DE LA SANTÉ  
 DIRECTION DE LA LUTTE CONTRE LA MALADIE  
 PROGRAMME NATIONAL DE LUTTE  
 CONTRE LE PALUDISME

BURKINA FASO  
*Unité - Progrès - Justice*

CARTE SANITAIRE DES 13 RÉGIONS DU BURKINA FASO

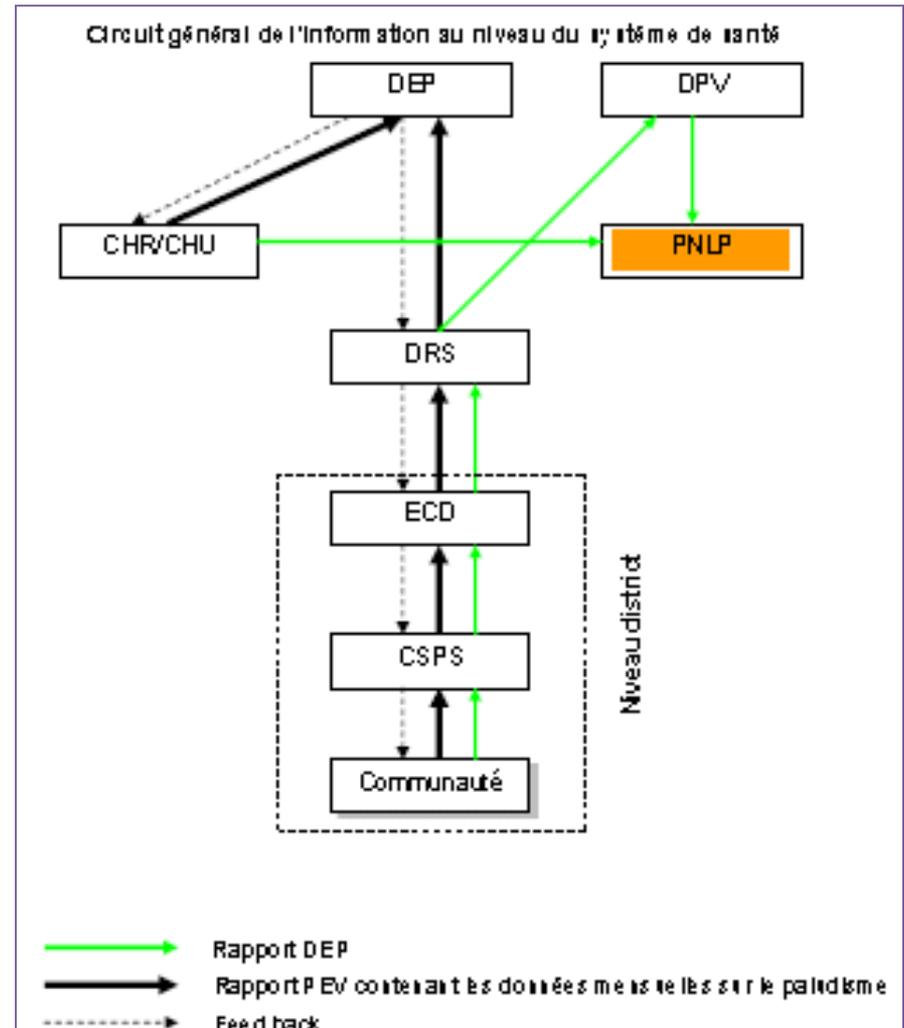


**PLAN DE SUR-EVALUATION DU PROGRAMME NATIONAL  
 DE LUTTE CONTRE LE PALUDISME DU BURKINA FASO,  
 2009-2010**



Septembre 2009

# National M&E Plan



# Malaria M&E Capacity

Partner	M&E Staff
PNLP	2
PADS	0
CNLS	1
PLAN	1

- The Global Fund recommends that “the additional PADS staff for M&E should be recruited as soon as the grant is signed
- “The recruitment of an M&E expert is budgeted for but the person is not yet recruited”

# Logistics Capacity

- Training in Logistics Management:
- Stores Keepers at the district and facility level have been trained in Logistics management
- They are not applying what they have learnt
- Stores keepers received handouts after the training in Logistics Management but there is no SOPs manual

# Inventory Control Management

- Max-min inventory control system not functioning
  - the Health facility supposed to have maximum level of 3 month of Stock, but not applying: they order the quantities based on their available budget
- Stock card not correctly -or not at all- used at the Health facility level (Petit Samba, CMA Yako, Pelgtanga)

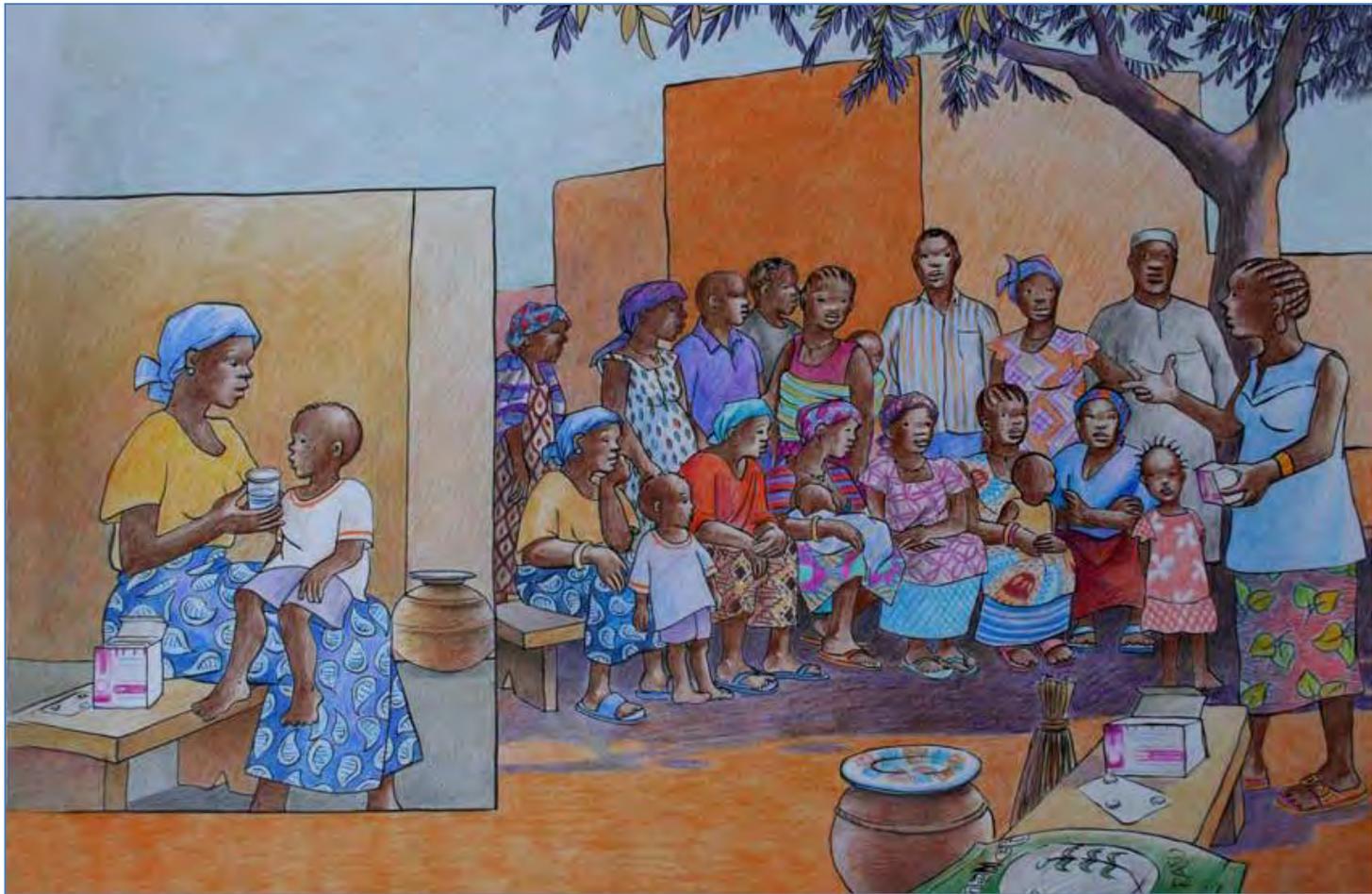
# Logistics Management Information System

- There is a tool for reporting
  - Rapport de progres sur la mise en Oeuvre des activités de lute contre le Paludisme dans les formations sanitaires
- Difficulty to get logistics essential data from the health facility

# Community Capacity

- Health Center Committees
  - Each primary health facility has one
  - Six members elected
  - Get share of money from sale of medicines to use for projects to improve care
- Community Health Agents
  - Usually two per community, a woman and a man
  - Primarily a voluntary role
  - Major focus on education and mobilization
  - Report to District Team, not nearby facility staff

# Community agents will be trained in health education and mobilization



# Planned Data Collection from Community Agents

FICHE DE COLLECTE DE DONNEES

Région sanitaire de : ..... District Sanitaire de : .....

CSPS de : ..... Village de : .....

Mois de : .....

					
<b>Malades de moins de 5 ans traités</b>	<b>Malades de plus de 5 ans traités</b>	<b>Malades de plus de 5 ans référés</b>	<b>Femmes Enceintes référées</b>	<b>Malades de moins de 5 ans référés</b>	<b>Séances d'IEC</b>

**NB : Cocher dans les cages correspondantes les nombres de cas traités, référés et de séances d'IEC menées**

# **Conclusions**

## **Recommendations for Work Planning**

# Issues for Action

- Readiness for LLIN universal coverage campaign
- Adequacy of RDT training roll out, supervision, and monitoring
- Lack of distinct MIP training
- Gaps in M&E systems
- Need for case management directives and job aids dissemination
- Role for private sector
- Logistics

# Readiness for LLIN universal coverage campaign

- There is still a gap of 1.4 million nets
- Tender not ready for R8 nets
  - Nets have not been ordered
  - Minimum of six months is needed
  - Date of campaign has already been pushed back from April to July
- National planning committee not yet formed to set realistic schedule for activities

# Adequacy of RDT training, roll out, supervision, and monitoring

- Supplies are not adequate (USAID to meet gap)
- Training is still only on a pilot basis
  - Not all facilities in pilot areas covered
  - Not well documented, reported
  - Follow-up monitoring and quality control system not in place
- Storage conditions, especially at facility level, not appropriate
- Attitudinal issues not well addressed – i.e. preference for presumptive treatment from clinical diagnosis

# Lack of distinct MIP training and programming gaps

- DFS does not perceive need for separate MIP training
- Existing FANC training slides woefully inadequate on MIP
- MIP prevention is 'hidden' under case management guidelines
- Old and revised job aid IPTp is available, but not widely distributed
- Confusion over free vs. cost recovery for SP

# MIP Gaps

- Poorly defined role for Community Agents to promote MIP activities
- ANC attendance gaps are not well addressed
- M&E for IPTp is based on inadequate record keeping
- ITN supplies and coverage for pregnant women is still inadequate

# Gaps in M&E Systems

- PNLP must go out and collect data directly from District team
  - NHIS system data flow irregular
  - PNLP cannot monitor quality
- PNLP acknowledges routine data from facilities is of poor quality
- Many tools, but not used properly
- Lack of connection between registers and summary sheets
- Community agent data not linked to facility

# Need for case management directives and job aids dissemination

- Only home-made job aids for case management and posters from pharmacy companies seen at facilities
- Staff have copies of case management directives from the time they were trained – e.g. 2003, 2005
- Need link between case management and RDT training and trainee/participant take home materials

# Role for private sector

- Standardization of medicine supplies in line with national case management directives
- Enhance RDT use in case management
- Enhanced opportunities for in-service training and access to job aids and guidelines
- We do not know how quantities of commodities procured and used in private sector fit into overall national projections

# Logistics

- While there are training materials and tools, these are not applied adequately to guarantee good tracking and planning
- Multiple partners are involved in commodities and logistics
- Better coordinating, supervisory and monitoring systems are needed to ensure adequate supplies and correct management

# Next Steps

- Identify any remaining training materials and guides, and remaining national guidelines and directives
- Determine better estimates of potential trainees at different levels
- Verify national malaria summary data
- Review PNLP Action Plan for 2009
- Develop IP specific work plans for final submission within one month
- Attend regular partnership meetings to ensure progress on program implementation to reach targets