

BURKINA FASO MALARIA PROFILE

I. ABOUT

Launched in 2005, the [U.S. President's Malaria Initiative \(PMI\)](#) supports implementation of malaria prevention and treatment measures as well as cross-cutting interventions. PMI's 2021–2026 strategy, [End Malaria Faster](#), envisions a world free of malaria within our generation with the goal of preventing malaria cases, reducing malaria deaths and illness, and eliminating malaria in PMI partner countries. PMI currently supports 24 countries in sub-Saharan Africa and three programs across the Greater Mekong Subregion in Southeast Asia to control and eliminate malaria. Burkina Faso began implementation as a PMI partner country in FY 2017. Please see the [Burkina Faso Malaria Operational Plan](#) for more information on PMI's approach and investments.

II. CONTEXT

Table 1: General Demographics and Malaria Situation

| | |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| Population | 22,163,838 (National Strategic Plan [NSP] 2021–2025) |
| Population at risk of malaria | 22,163,838 (NSP 2021–2025) |
| Malaria prevalence¹ | 17% (2017–2018 Malaria Indicator Survey [MIS]) |
| Malaria incidence/1,000 population at risk | 568/1,000 (National Malaria Control Program [NMCP], Health Management Information System (HMIS) 2021 [preliminary unvalidated data]) |
| Peak malaria transmission | May to October |

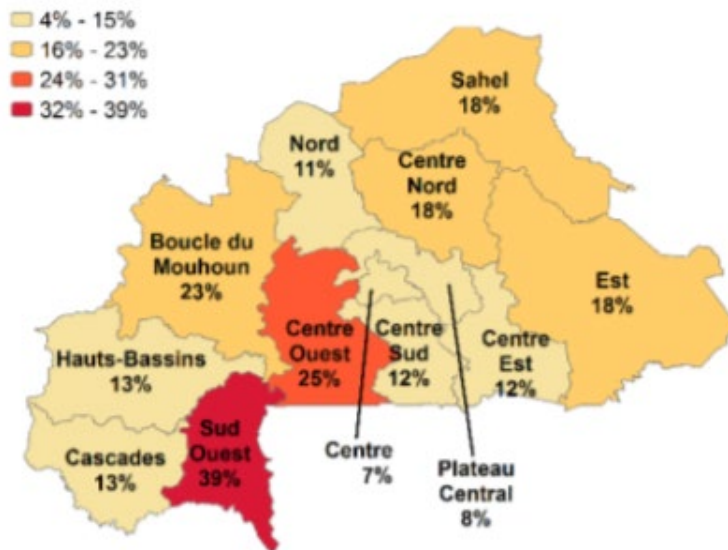
¹ Percent of children under five years of age with parasitemia by microscopy.

STRATIFICATION

A stratification exercise is currently in progress.

Figure 1: Prevalence Maps

Malaria prevalence by geographic area: Children 6 to 59 months of age who tested positive for malaria by microscopy [2017–2018 MIS*]



* Note that the 2017 – 2018 MIS was implemented in the low-transmission season; therefore, these data may be underestimated.

Malaria prevalence by geographic area: Children 6 to 59 months of age who tested positive for malaria by microscopy [2014 MIS]

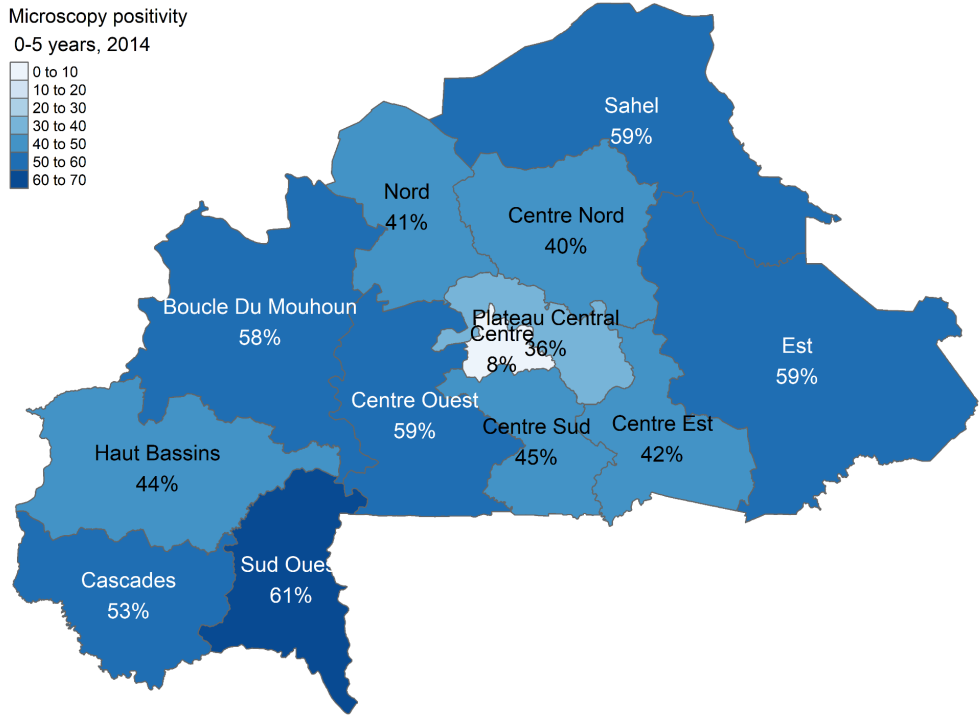
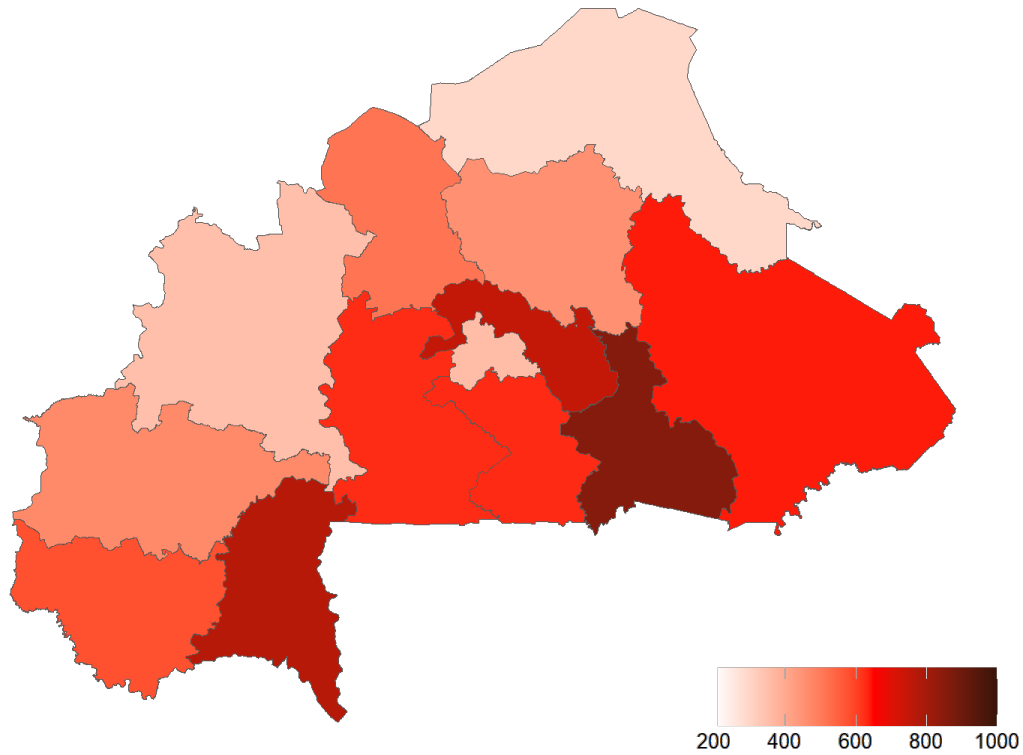


Figure 2: 2020 Incidence Map by Region



Source: Statistical Yearbooks

Table 2: Malaria Parasites and Vectors

| | |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Principal Malaria Parasites | <i>Plasmodium falciparum</i> (NSP 2021–2025) |
| Principal Malaria Vectors* | Members of the <i>Anopheles gambiae</i> complex are the principal vectors. In the western and southern part of the country <i>An. gambiae</i> predominates, <i>An. coluzzii</i> in the north central and eastern region with <i>An. arabiensis</i> interspersed. (NSP 2021–2025) |

*See **Entomological Monitoring** section of the Malaria Operational Plan for more details on vector bionomics and insecticide resistance and **Indoor Residual Spraying** section for details on residual efficacy.

COUNTRY HEALTH SYSTEM

At the administrative level, the health system in Burkina Faso is organized into three levels:

- The central level is responsible for developing and monitoring the implementation of policies, mobilizing resources, management, and performance evaluation.
- The intermediate level is responsible for coordination and support to the districts.
- The peripheral level is responsible for planning, management, and organization of health care provision.

Provision of Health Care Services

In terms of health care provision, there are three sub-sectors: the public sub-sector, the private sub-sector, and the traditional medicine sub-sector.

In the public sub-sector, according to the 2020 Statistical Yearbook, the health infrastructure includes five university hospitals at the tertiary level, nine regional hospital centers and one university hospital center at the secondary level, and 2,158 health care establishments at the primary level. In addition, specialized centers for cancer, neurosurgery, physical medicine and rehabilitation, traditional medicine, and integrated care are being created. The positioning of these centers in the architecture of the health pyramid remains to be determined.

Private facilities are concentrated in the major cities, with three hospitals at the tertiary level, eight polyclinics at the secondary level, 286 health care establishments at the primary level, plus 593 other health care structures, 243 pharmacies, and 661 pharmaceutical depots. Approximately 30,000 traditional health practitioners work individually in health care offices and herbalist shops.

In addition to the health care facilities, there is also a comprehensive community health system which includes community health workers (CHWs) (*agents de santé à base communautaire*), community-based organizations, and other civil society actors involved in the health sector.

Under the current strategic plan for community health, there are two CHWs in each village (except in urban and peri-urban areas). The malaria prevention and control activities that the CHWs are permitted to perform depend upon their distance from the nearest health facility. CHWs who are less than 5 km from the nearest health facility provide health promotion services, participate in prevention campaigns, and refer people to the nearest health facility. In addition to these functions, CHWs who are 5 km or more from the health facility are also able to provide malaria rapid diagnostic tests

(RDTs), treat simple malaria, and in some parts of the country to provide pre-transfer treatment for severe malaria with rectal artesunate.

At present, only a small proportion of malaria cases are reported by CHWs (see Table 5). However, the proportion has been increasing each year since the current community health system was introduced under the 2019–2023 National Strategy for Community Health. Additional support for training and supervision of CHWs, as well as for ensuring commodities are consistently available at the community level, is needed to accelerate progress towards increased community-level malaria case management.

All health facilities, including the private sector, provide malaria diagnostic tests as well as malaria treatment. At the peripheral level, the RDT for malaria is used, while at the hospital, microscopy is also available in addition to the RDT.

The NMCP collaborates with the Division of Maternal and Reproductive Health through the National Coordinating Committee for Malaria. A technical group on case management and medical prevention, which includes malaria in pregnancy (MIP) and of which the maternal and child health staff is a member, is hosted by the malaria steering committee and meets to consider relevant technical issues.

Since 2016, Burkina Faso has been implementing a policy of free health care for children under 5 years of age and pregnant women. Although some private insurance and pooled payment options exist in the country, the majority of other health care recipients pay for their care directly.

Supply Chain Management

Malaria commodities, along with all other essential products, are managed through the central medical stores known as CAMEG (*Centrale d'achat des médicaments essentiels génériques et des consommables médicaux*), which is a non-profit organization created by presidential decree in 1992. All essential products, regardless of source, enter the supply chain through CAMEG, which provides quality assurance, storage, and distribution services to the district level. CAMEG does not provide distribution services from the district warehouses to points of care, and representatives from health facilities are responsible for transporting commodities from the district level to their facility.

Health Information Systems

There are two major routine health information systems in Burkina Faso, the National Health Information System (known as the electronic HMIS or ENDOS) — *Système National d'Information Sanitaire (SNIS)* — which collects monthly health facility reports—through district and regional level health information centers—in a District Health Information System² (DHIS2) platform. There is also a weekly Integrated Disease Surveillance and Response system (IDSR) known as the TLOH, which is an

Excel-based system. The NMCP produces a weekly malaria bulletin using TLOH data, and annual reports are produced using the ENDOS data. In addition to the two major systems, there is a large number of health data sources and systems. A recent evaluation of the health information system identified 110 active databases, applications, and digital tools.






The Ministry of Health (MOH) Data Management Directorate (*Direction des Statistiques Sectorielles* or DSS) is in the process of finalizing a new strategic plan for ENDOS. One of the objectives under the new plan is to reduce fragmentation in the system.

In addition to the streamlining efforts underway for the wider routine health information systems, the NMCP is in the process of developing a DHIS2-based malaria data repository and accompanying dashboards.

OTHER CONTEXTUAL INFORMATION

According to the Global Terrorism Index 2022,¹ Burkina Faso is the country with the fourth highest impact of terrorism in the world, with three of the 10 most deadly terrorist attacks in 2021 occurring in Burkina Faso. It is also noted that in 2021, Burkina Faso experienced the second highest number of total terrorism deaths after Afghanistan. The report describes the underlying drivers of the rapidly deteriorating situation in the Sahel as complex and systemic, including poor water utilization, lack of food, malnutrition, strong population growth, and weak governments.

Figure 3: Global Terrorism Index 2022, Impact of Terrorism Ranking

| RANK | COUNTRY | SCORE |
|-------------|--------------------------------------------------------------------------------------------------|--------------|
| 1 |  Afghanistan | 9.109 |
| 2 |  Iraq | 8.511 |
| 3 |  Somalia | 8.398 |
| 4 |  Burkina Faso | 8.270 |
| 5 |  Syria | 8.250 |

The deteriorating security situation has led to what the United Nations Office for the Coordination of Humanitarian Affairs describes as a multidimensional humanitarian crisis. The Humanitarian Response Plan, published in March 2022, covers all 13

¹ Institute for Economics & Peace. Global Terrorism Index 2022: Measuring the Impact of Terrorism, Sydney, March 2022. Available from: <http://visionofhumanity.org/resources>.

regions of the country and estimates that more than 5 million people are impacted by the crisis, with an estimated 3.5 million currently experiencing acute need for humanitarian assistance. Additionally, as of February 28, 2022, there were 1.8 million people internally displaced as a result of ongoing violence (up from fewer than 50,000 in late 2018).

The health sector has been both directly and indirectly affected by the worsening security situation. Also as of February 28, 2022, the MOH reported that 499 health facilities were affected by insecurity, 160 of which are completely closed, leaving an estimated 1.9 million individuals with restricted access to health care. Health facilities have been targeted with violence, and 94 percent of the health facility closures are reportedly due to direct attacks by unidentified armed groups on the facilities themselves. Access to health care is also being indirectly impacted by the pressure on services resulting from large flows of internally displaced persons and lack of access to some populations due to armed groups cutting off and surrounding certain zones.²

Burkina Faso is also currently experiencing political instability. After a coup d'état on January 24, 2022, a transitional government is currently in place. Under the current transition charter the transition period is fixed at 36 months.

III. NMCP STRATEGIC PLAN

The current NSP for Malaria Control, which covers 2021–2025, draws from the overall National Plan for Economic and Social Development 2020–2022, which emphasizes malaria control and is in line with the Government of Burkina Faso's long-term vision of eliminating malaria in Burkina Faso by 2030. The NSP 2021–2025 objectives align with the World Health Organization's (WHO) Global Technical Strategy and PMI's Strategy, provided below:

- Reduce the malaria death rate in Burkina Faso by 75 percent from 2015 levels by 2025.
- Reduce the malaria incidence rate in Burkina Faso by 75 percent from 2015 levels by 2025.
- Reinforce NMCP malaria program management capacities in Burkina Faso by 2025.

² Bulletin N°25 du Cluster Santé, Burkina Faso: February 2022
<https://www.humanitarianresponse.info/en/operations/burkina-faso/document/bfa-bulletin-humanitaire-du-cluster-sant%C3%A9-f%C3%A9vrier-2022>

The NSP 2021–2025 builds on the previous NSP and emphasizes the following focus areas:

- Parasitological diagnosis of malaria at public and private health facilities, community levels, and through quality control/quality assurance of laboratories.
- Treatment of malaria cases at public and private health facilities as well as at the community level.
- Prevention of MIP using intermittent preventive treatment for pregnant women (IPTp) with sulfadoxine-pyrimethamine (SP) and by providing insecticide-treated mosquito nets (ITNs) through routine distribution channels.
- Seasonal malaria chemoprevention (SMC) for children 3 to 59 months of age.
- Vector control through universal access to ITNs, implementation of indoor residual spraying and larval source management in targeted areas, and management of insecticide resistance.
- Strengthening of communication through advocacy and social and behavior change.
- Strengthening commodity supply chain management.
- Surveillance, monitoring, evaluation, and research.
- Epidemic control and emergency management.
- Strengthening malaria program management.

Of the 10 focus areas highlighted in the NSP 2021–2025, nine are aligned with PMI-supported key intervention areas and receive varying levels of PMI funds. Epidemic control and emergency management is a focus area of the NSP that has not to date received PMI support.

IV. KEY MALARIA DATA

EVOLUTION OF KEY SURVEY BASED MALARIA INDICATORS

Table 3: Key Survey Indicators

| Indicator | 2014 MIS | 2017 – 2018 MIS | 2021 DHS* |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------|-----------|
| % Households with at least one ITN | 90 | 75 | 83 |
| % Households with at least one ITN for every two people | 49 | 33 | |
| % Population with access to an ITN | 71 | 55 | |
| % Population that slept under an ITN the previous night | 67 | 44 | 41 |
| % Children <5 years of age who slept under an ITN the previous night | 75 | 54 | 79 |
| % Pregnant women who slept under an ITN the previous night | 77 | 58 | 83 |
| % Children <5 years of age with a fever in the last two weeks for whom advice or treatment was sought | 63 | 74 | 75 |
| % Children <5 years of age with a fever in the last two weeks who had a finger or heel stick | 30 | 49 | 65 |
| % Children receiving an artemisinin-based combination therapy among children <5 years of age with a fever in the last two weeks who received any antimalarial drug | 28 | 79 | 49 |
| % Women who attended 4 antenatal care (ANC) visits during their last pregnancy | 48 | 82 | |
| % Women who received three or more doses of IPTp during their last pregnancy in the last two years | 23 | 58 | 57 |
| <5 mortality rate per 1,000 live births | 129 (2010 DHS) | | 48 |
| % Children <5 years of age with parasitemia by microscopy | 46 | 17 | 14 |
| % Children <5 years of age with parasitemia by RDT | 61 | 20 | 28 |

DHS: Demographic and Health Survey

Figure 4. ITN Use:Access Ratio Map

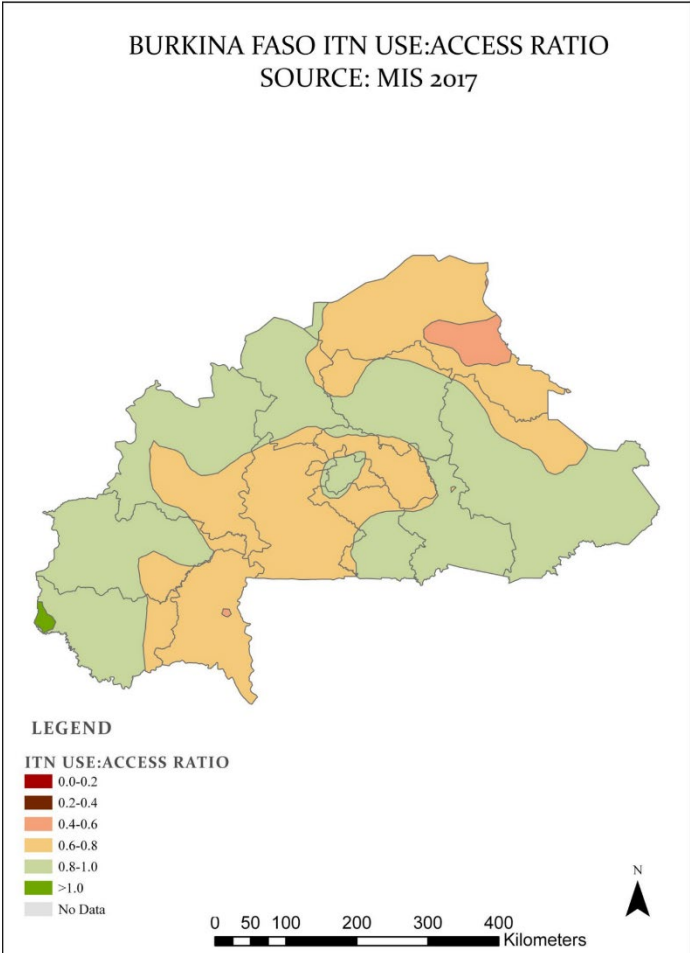


Table 4: Evolution of Key Malaria Indicators Reported through Routine Surveillance Systems*

| Indicator | 2017 | 2018 | 2019 | 2020 | 2021 |
|---------------------------------------------------------------|------------|------------|------------|------------|------------|
| # All-cause patient consultations | 28,158,858 | 30,501,472 | | 29,739,180 | 32,789,481 |
| # Suspect malaria cases ¹ | N/A | 15,339,224 | 18,116,946 | 15,109,304 | 16,954,871 |
| # Patients receiving diagnostic test for malaria ² | N/A | 13,636,115 | 16,267,503 | 13,641,055 | 16,851,052 |
| Total # malaria cases ³ | 11,915,816 | 11,970,321 | 13,020,946 | 11,311,560 | 12,231,086 |
| # Confirmed cases ⁴ | 10 527 304 | 10,589,000 | 12,120,940 | 10,347,928 | 11,557,181 |
| # Presumed cases ⁵ | 1,388,512 | 1,381,321 | 900,006 | 963,632 | 673,905 |
| % Malaria cases confirmed ⁶ | 88.3% | 88.5% | 93.1% | 91.5% | 94.49% |
| Test positivity rate (TPR) ⁷ | 81% | 77% | 74.5% | 75.9% | 68.5% |
| Total # children <5 years of age malaria cases ⁸ | 6,082,216 | 5,870,314 | N/A | 4,885,842 | 4,868,717 |
| % Cases in children <5 years of age ⁹ | 51% | 49% | N/A | 43.19% | 39.8% |
| Total # severe cases ¹⁰ | N/A | 506 513 | 236,909 | 508,282 | 605,504 |
| Total # malaria deaths ¹¹ | 4,144 | 4,294 | 3,830 | 3,983 | 4,355 |
| # Facilities reporting ¹² | N/A | 2,648 | 3,204 | 2,831 | 3,287 |
| % Data completeness ¹³ | 95% | 93% | 60.2% | 89.3% | 96.5% |

*Community-level data are integrated into the broader HMIS, and these numbers are inclusive of both community- and health facility-level data.

1 Number of patients presenting with signs or symptoms possibly due to malaria (presenting with fever or history of fever); 2 RDT or microscopy, all ages, outpatient and inpatient; 3 Total reported malaria cases; all ages, outpatient and inpatient, confirmed and unconfirmed cases; 4 Diagnostically confirmed; all ages, outpatient and inpatient; 5 Clinical/presumed/unconfirmed; all ages, outpatient and inpatient; 6 # confirmed cases divided by total # cases; 7 Confirmed cases divided by # patients receiving a diagnostic test for malaria (RDT or microscopy); 8 Outpatient and inpatient, confirmed and unconfirmed; 9 Total # children <5 years of age cases divided by total # of cases; 10 Number of confirmed cases with at least one of the clinical or biological signs of severity as listed in the NMCP case management guidelines; 11 All ages, outpatient, inpatient, confirmed, and unconfirmed; 12 Total # of health facilities reporting data into the HMIS/DHIS2 system that year; 13 # monthly reports from health facilities divided by # health facility reports expected (average for the calendar year).

Table 5: Disaggregated Community-Level Data

| Indicator | 2019 | 2020 | 2021 |
|------------------------------------------------------------------|---------|---------|---------|
| # Patients receiving diagnostic test for malaria from a CHW | 127,617 | 243,397 | 367,844 |
| Total # of malaria cases reported by CHWs ¹ | 86,471 | 171,048 | 247,746 |
| % of CHW reported cases (among total malaria cases) ² | 0.66% | 1.51% | 2.03% |

1 Includes all ages, confirmed and unconfirmed.

2 Total # malaria cases reported by CHWs/Total # malaria cases in previous table.

V. OTHER IMPLEMENTATION INFORMATION

PMI supports standard durability monitoring of all three types of ITNs distributed during the 2019 mass campaign: Interceptor G2, a dual-active ingredient ITN in Banfora health district (Comoé province); Interceptor, a standard pyrethroid ITN in Gaoua health district (Poni province); and PermaNet 3.0, a pyrethroid ITN with the insecticide synergist piperonyl butoxide (PBO), in Orodara health district (Kéné Dougou province). The 2019 mass distribution campaign took place in three stages, between June and October and distribution timings for the study sites differed: PermaNet 3.0 ITNs were distributed between June and July, Interceptor ITNs in August and dual AI (G2) ITNs in October.

The study compared the attrition, physical durability, survivorship, and bio-efficacy of nets distributed and sought to identify major determinants of field performance. Baseline data collection was conducted in December 2019; the 12-month data collection survey was carried out between August and November 2020, and the 24-month data collection survey was carried out between July to November 2021. During each follow up, ITNs labeled at baseline were monitored for physical integrity of nets still present in the household and details recorded for any nets no longer present in the household (attrition). Potential factors affecting net durability were explored through a household interview. Information on ITNs obtained by the household outside of the 2019 campaign were also collected. ITN samples were also tested for bio-effectiveness and chemical content analysis.

Insecticides bioassays and tunnel tests conducted at 24 months for insecticide effectiveness showed differences in bio-effectiveness. Interceptor samples (from Gaoua) and G2 (Banfora) had optimal effectiveness while PermaNet 3.0 (Orodara)

achieved 97 percent effectiveness (with the side panels showing reduced effectiveness compared to the roof panel). Results of available chemical test of ITN samples showed that after 13 months of field usage, there was 45 percent loss alpha-cypermethrin in Interceptor, 27 percent loss of chlorfenapyr, and 4 percent loss of alpha-cypermethrin in interceptor G2 while PermaNet 3.0 showed 18 percent loss of deltamethrin and an average of 62 percent loss on PBO content.

Table 6: Results of Durability Monitoring

| Site/Net Type | Survey and Time Since Distribution (months) | Attrition to Wear and Tear (%) | Nets in Serviceable Condition (%) | Optimal Insecticidal Effectiveness in Bioassay (%) |
|----------------------|---------------------------------------------|--------------------------------|-----------------------------------|----------------------------------------------------|
| Banfora/G2 | 1.4 | 0 | 100 | - |
| | 12 | 1.4 | 96.5 | - |
| | 24.1 | 13.9 | 84.2 | - |
| Orodara/PermaNet 3.0 | 5.5 | 0 | 94.7 | - |
| | 14.4 | 5.1 | 95.7 | - |
| | 24.2 | 15.9 | 90.4 | - |
| Gaoua/Interceptor | 4.3 | 0 | 98.7 | 100 |
| | 13.1 | 9.7 | 97.1 | 100 |
| | 24.1 | 26.0 | 88.4 | 100 |

Table 7: Summary of Completed Therapeutic Efficacy Studies

| Year | Site | Treatment arm | Efficacy (PCR-corrected adequate clinical and parasitological result) for each drug at each site |
|-----------|------------|---------------|--------------------------------------------------------------------------------------------------|
| 2017–2018 | Gourcy | AL | 76% [66, 83] |
| 2017–2018 | Nanoro | AL | 74% [64, 83] |
| 2017–2018 | Niangoloko | AL | 92% |
| 2017–2018 | Gourcy | DP | 84% [75, 89] |
| 2017–2018 | Nanoro | DP | 89% [81, 94] |
| 2017–2018 | Niangoloko | DP | 97% |

PCR=polymerase chain reaction; AL=artemether-lumefantrine; DP=dihydroartemisinin-piperaquine

Citation: Gansané, A., Moriarty, L.F., Ménard, D. et al. Anti-malarial efficacy and resistance monitoring of artemether-lumefantrine and dihydroartemisinin-piperaquine shows inadequate efficacy in children in Burkina Faso, 2017–2018. *Malar J* 20, 48 (2021). <https://doi.org/10.1186/s12936-021-03585-6>

VI. KEY POLICIES

Table 8: Policies in Burkina Faso

| |
|---------------------------------------------------------------------------------------------------------------|
| National Strategic Plan 2021–2025 , NSP December 2020 |
| National Surveillance, Monitoring, and Evaluation Plan: <i>Guide de Surveillance</i> , i November 2021 |
| National Health Information System Strategy 2021–2025 (plan in development) |
| National eHealth Strategy: Proposed (development not yet in progress) |
| 2021–2025 Integrated Vector Management Plan: November 2020 |
| Malaria Case Management Policy: National Malaria Treatment Guidelines December 2020 |

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| What is/are the first-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*? | Dihydroartémisinine + Pipéraquline (DHA-PPQ) Artésunate+pyronaridine (AP) Artemether+lumefantrine (AL) |
| What is/are the second-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*? | N/A |
| What is the first-line treatment for severe malaria? | Injectable artesunate Injectable artemether |
| In pregnancy, what is the first-line treatment for uncomplicated <i>P. falciparum</i> malaria in the <u>first trimester</u> ? | Quinine |
| In pregnancy, what is/are the first-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria in the <u>second and third trimesters</u> ? | DHA-PPQ AP AL |
| In pregnancy, what is the first-line treatment for severe malaria? | First trimester : Quinine Second and third trimester: Injectable artesunate Injectable artemether |
| Is pre-referral treatment of severe disease recommended at peripheral health facilities? If so, with what drug(s)? | Yes. Injectable artesunate Injectable artemether Quinine |
| Is pre-referral treatment of severe disease with rectal artesunate recommended for community health workers? | Yes |
| Community Health Policy: <i>La Stratégie nationale de santé communautaire</i> 2019–2023, December 2018 | |
| What is the # of CHWs currently providing integrated community case management (iCCM)? | 9,899 (Quarter 3, 2021) |
| What is the country's target for the number of CHWs providing iCCM? | 17,668 (Target is 100% of CHWs) |
| What percent of the country's target is met? | 56% |
| Does the country have a policy that enables the routine, regular payment of salaries/stipends for CHWs? | Yes |

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Do CHWs have the authority to test and treat all ages for malaria? | Yes: except for children under 2 months, pregnant women, and when severe malaria is suspected. (CHWs >5 km from a health facility only) |
| Prevention of MIP Policy National Guidelines for Management of Malaria, December 2020 | |
| At what gestational age is the first dose of IPTp-SP to be given to pregnant women according to the national guidelines for malaria and MCH? | 16 months |
| Do the national ANC guidelines reflect the WHO 2016 recommendation of 8 ANC scheduled contacts (plus one additional contact for early initiation of IPTp at 13-16 weeks)? If not, how many ANC contacts are recommended? | 4 ANC contacts currently scheduled, but adoption of WHO recommendation is ongoing. |
| What is the status of training ANC providers on the WHO recommended 8+ contacts? | Not started yet. Adoption of WHO recommendation is ongoing. |
| Have HMIS/DHIS2 and ANC registers been updated to include 8+ contacts? | Not yet |
| Are IPTp data collected as single months where the January 2022 data represent the number of doses administered in January 2022, or cohort data, representing the cumulative data from pregnancies which began 6 months prior? | |
| Is ANC/IPTp provided by facility staff conducting ANC outreach to communities? | Yes |
| Can CHWs deliver IPTp and if so, which specific cadres and beginning with which dose? | Ongoing in pilot areas. |

VII. PARTNER LANDSCAPE

Table 9: Partner Landscape

| Partner | Key technical interventions | Geographic coverage | Funding amount or in-kind contribution | Timeframe |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------|
| Global Fund | <ul style="list-style-type: none"> • Support for nationwide mass campaign in 2022 • Procurement of national needs for SP • Training and supportive supervision in 10 regions • SBC nationwide • Community Health system strengthening | <ul style="list-style-type: none"> • National for ITN campaign • 10 of 13 regions for other activities | \$92.3 million | Current grant covers 2021 to 2024 |
| Malaria Consortium | <ul style="list-style-type: none"> • Support for SMC campaign | 27 districts | \$7.3 million | Annually |