

BURUNDI MALARIA PROFILE

I. ABOUT

The U.S. Agency for International Development (USAID) delivers cost-effective, lifesaving malaria interventions alongside catalytic technical and operational assistance to support Burundi to end malaria. USAID has been a proud partner of Burundi since 2010, helping to decrease malaria-related child death rates by 19 percent and through investments totaling almost \$109 million. USAID support aligns with the National Malaria Strategic Plan 2018-2027, based on the World Health Organization’s (WHO) technical strategy 2015-2030 and U.S. President’s Malaria Initiative’s (PMI’s) 2021–2026 strategy, *End Malaria Faster*, with the goal of preventing malaria cases, reducing malaria mortality and morbidity, and controlling the epidemic. Please see the [Burundi Malaria Operational Plan](#) for more information on USAID’s malaria approach and investments.

II. CONTEXT

The purpose of this section is to familiarize the reader with the malaria situation and general operating context in the country. The information will be reviewed and updated when there are significant changes (e.g., new population or survey data available, new strategy, changes to administrative divisions, etc.).

Table 1: General Demographics and Malaria Situation

Population	11,703,735 inhabitants in 2022 (<i>Institut de Statistiques et d’Etudes Economiques du Burundi</i> (ISTEEBU), projection of population 2008-2030, based on the 2008 General Census)
Population at risk of malaria	100%
Malaria prevalence	27% (Demographic and Health Survey [DHS] 2016-2017)
Malaria incidence/1,000 population at risk	606.8/1,000 population at risk (District Health Information Software 2 [DHIS2], 2021)

During FY 2022, the Government of Burundi created two new districts. The former two districts of Kinyinya (Ruyigi province) and Bururi (Bururi province) have been respectively divided into two new districts — the health district of Gisuru and the health district of Rutovu — increasing the number of districts in Burundi from 47 to 49.

STRATIFICATION

Figure 1: Classification of Provinces by Epidemiological Risk after the Stratification Exercise in 2021

The map below shows a new epidemiological risk established in 2021 by the stratification exercise dividing Burundi in four zones: 1) a **very high**-risk zone with incidence covering the northeast and central regions, covering six provinces Kirundo, Muyinga, Karuzi, Cankuso, Ruyigi, and Ngozi, representing 17 of the 49 health districts; 2) a **high**-risk zone covering 14 districts, consisting of the belt running from the northwest to the southeast; 3) a **medium**-risk zone made up of parts of the north, central west, and southwest covering 12 districts; and 4) a **very low**-risk zone made up of the south and center-west of Burundi covering six health districts.

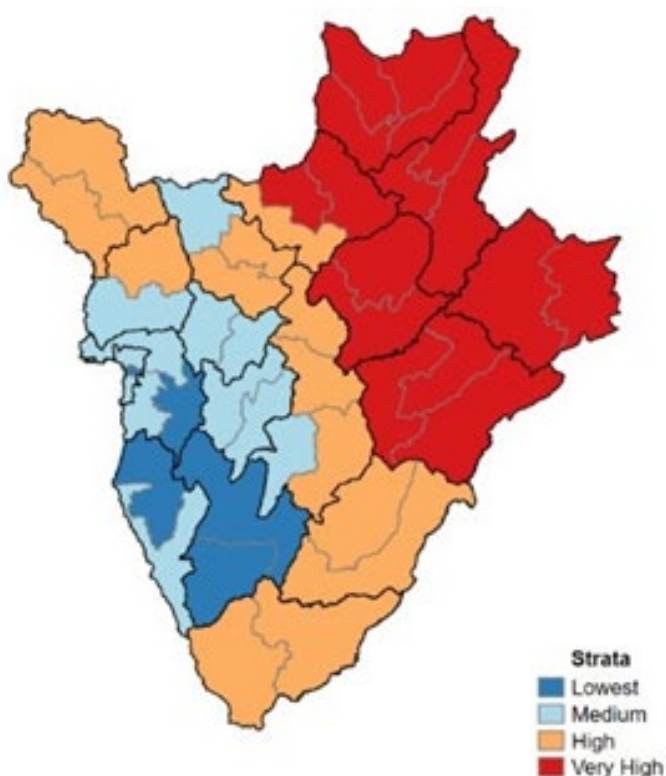
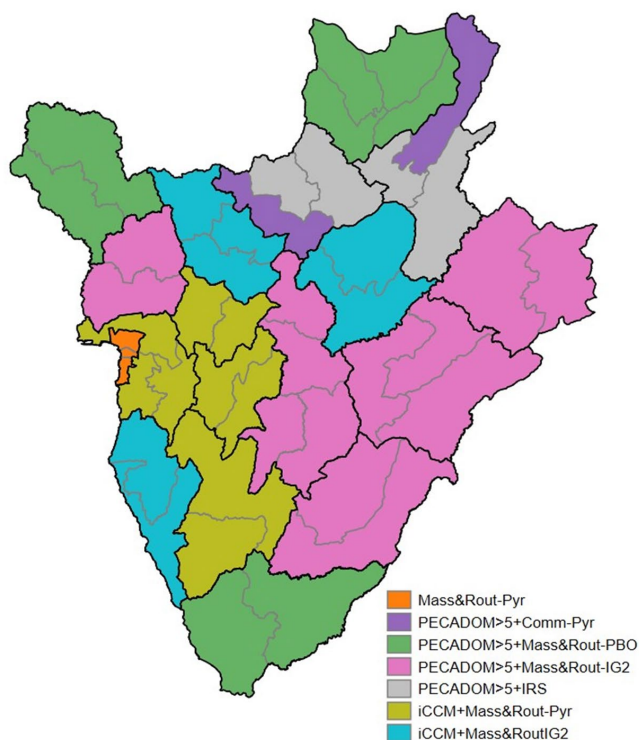


Figure 2: Recommended Combination of Interventions by Province from the 2021 WHO Stratification Exercise

The map below from the stratification exercise in 2021 shows the type of interventions to implement by province. Seven combinations of the key interventions highlighted will help to control the malaria epidemic.



	Intervention mix*	Population	% of total population	Number of provinces
	Mass campaign & Roll out-pyrethroid ITNs	645,352	6.2	1
2	PECADOM>5** + Community distribution of pyrethroid ITNs	647,995	6.2	2 districts***
3	PECADOM>5 + Mass campaign Roll out - PBO	2,013,414	19.2	3
4	PECADOM>5 + Mass campaign Roll out IG2	2,606,285	24.8	5
5	PECADOM>5 + IRS	1,037,343	9.9	2
6	iCCM + Mass campaign & Roll out-pyrethroid ITNs	1,744,159	16.6	4
7	iCCM + Mass campaign Roll out IG2	1,795,763	17.1	3
7	iCCM + Mass campaign Roll out IG2	1,795,763	17.1	3

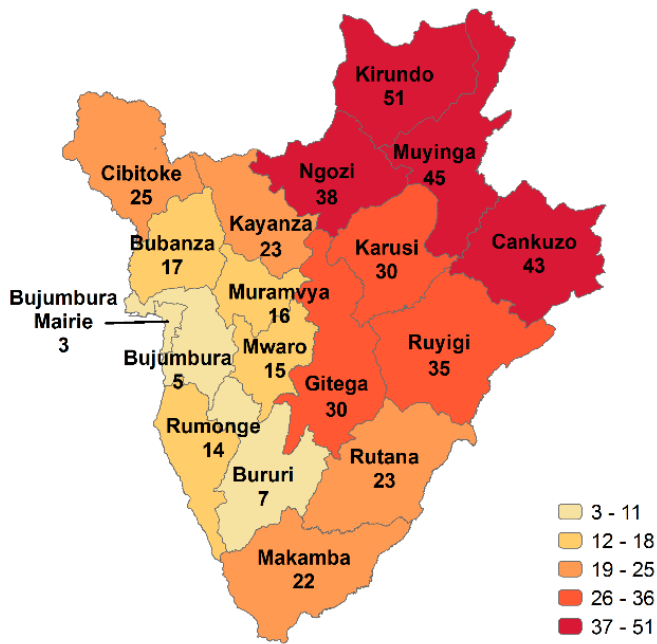
ITN: Insecticide-treated mosquito net. PECADOM: *Prise en charge à domicile (home-based management)* – Community case management of malaria for all ages; IRS: Indoor residual spraying; iCCM: integrated Community Case Management; IG2: Interceptor G2 nets

* Case management and intermittent preventive treatment for pregnant women (IPTp) are recommended in all 18 provinces

** PECADOM=Community case management of malaria for all ages in addition to iCCM for children under five years of age.

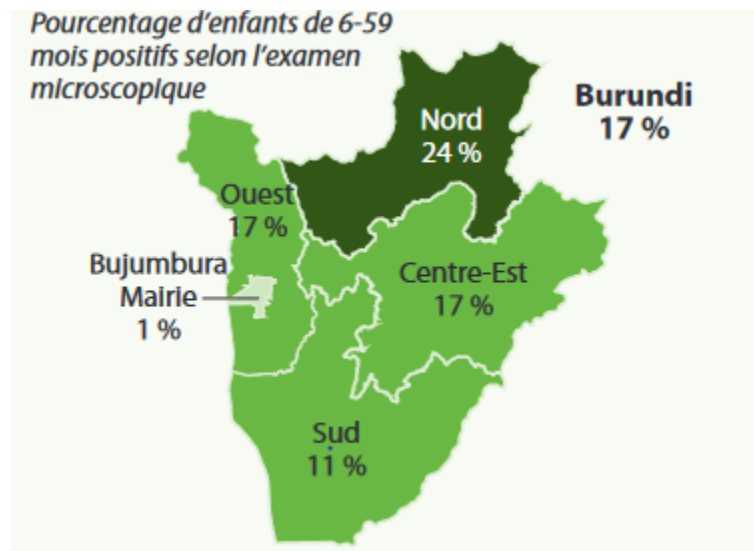
*** 2 districts of the intervention combining PECADOM and IRS.

Figure 3: Prevalence Maps



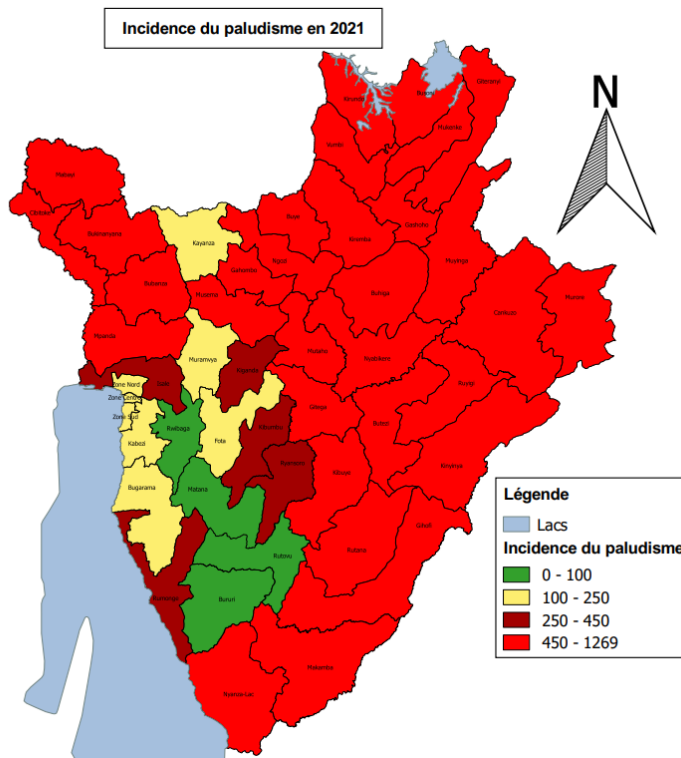
Source: DHS, 2016-17

Percentage of children 6 to 59 months of age who tested positive for malaria by microscopy



Source: Malaria indicator survey (MIS), 2012

Figure 4: Incidence Maps
2021



For the calendar year (CY) 2021, the situation was as follows for incidence:

- 0 to 100 cases of malaria per 1,000 inhabitants: 4 health districts
- 100 to 250 cases of malaria per 1,000 inhabitants: 8 health districts
- 250 to 450 cases of malaria per 1,000 inhabitants: 5 health districts
- 450 to 1,269 cases of malaria per 1,000 inhabitants: 32 health districts

Note that while this map from 2021 shows 48 health districts, a new district (Gisuru) was created in FY 2022 from the two districts of Ruyigi and Kinyinyam, both of which are located in the high malaria incidence area.

2020

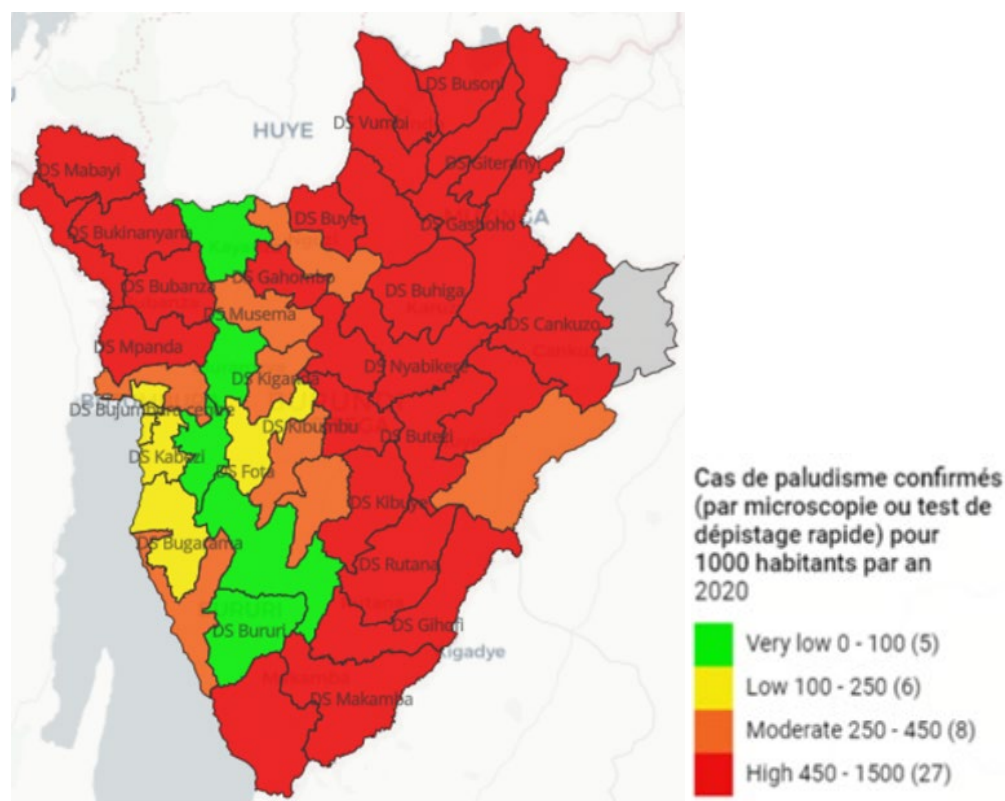


Table 2: Geography and Climate

Principle Malaria Parasites	<i>Plasmodium falciparum</i> , (81.6%), <i>Plasmodium malariae</i> (12.5%) and <i>Plasmodium ovale</i> (5.8 %).
Principal Malaria Vectors*	Primary species; <i>Anopheles gambiae</i> , <i>Anopheles funestus</i> . Secondary species: <i>Anopheles ziemanni</i> , <i>Anopheles coustani</i> , <i>Anopheles squamosus</i> , and <i>Anopheles maculipalpis</i> , <i>Anopheles Arabiensis</i>

Insecticide resistance monitoring was conducted in nine sentinel sites from October 2020 to November 2021. Of the nine sentinel sites, Kiremba received IRS and the others are non-IRS sites of Cankuzo, Gihofi, Mabayi, Matana, Mpanda, Mutaho, Nyanza-Lac, and Vumbi.

The most recent entomological monitoring report showed resistance of malaria vectors to permethrin in Nyanza Lac with 84 percent mortality. A partial restoration of the susceptibility to permethrin was observed after exposure to piperonyl butoxide (PBO) prior to permethrin with an increase of 13% of mortality. A possible malaria vector resistance to deltamethrin was observed in Gihofi with 96% mortality; otherwise, the vector is susceptible to pyrethroids at most sentinel sites. The vector is fully susceptible to clothianidin, a mixture of clothianidin and deltamethrin, pirimiphos-methyl, and bendiocarb.

* 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

The health care system is organized through a four-tier system: community level, operational level (health centers, district hospitals), intermediate level (four regional hospitals), and central level (four national hospitals). In addition to the national hospitals, there are private hospitals and clinics that participate in health care activities. The public health centers are the gateway to the health care network and offer a minimum package of activities, including health promotion, along with preventive, curative, and rehabilitative care. The district hospital is the first level of referral and offers a complementary package of curative activities, including the management of severe malaria. Regional hospitals are the second level of referral offering specialized health packages. Finally, the national referral hospital offers high-level specialized services. Private sector facilities provide curative health care and represent 27 percent of the total number of health centers. In total, Burundi has 1,251 health centers and clinics, of which 657 are public centers, 399 are private-for-profit clinics, 155 are faith-based, and 40 are community-based centers. There are 80 hospitals, of which 51 are public hospitals at the regional level, plus 10 private-for-profit hospitals, 18 faith-based hospitals, and one is a community-based hospital set up by a civil society organization (Source: *Annuaire statistique*, 2020). Most of these faith-based facilities and all the private-for-profit facilities have no access to malaria commodities for preventive or curative care. Health facilities experience staff shortages and rapid turnover. According to the 2016–2017 DHS, the majority of Burundians do not have medical insurance — 78 percent among women and 79 percent among men — while health care is subsidized for children under five years of age, for pregnant women for pregnancy-related illnesses, and for malaria diagnosis and treatment.

Malaria in pregnancy (MIP): According to the Burundi National Malaria Control Strategic Plan (NMCSPP), the objectives of the MIP program are to ensure that every pregnant woman receives at least three doses of sulfadoxine-pyrimethamine (SP) for IPTp. Each dose is administered under directly observed therapy during antenatal care (ANC) visits, starting in the second trimester (13 weeks gestation), at one-month intervals, and up to the day of delivery. Additionally, each pregnant woman receives an ITN at her first ANC visit. The treatment of uncomplicated malaria in pregnant women within the first trimester is a combination of quinine + clindamycin, and artemether-lumefantrine (AL) in the second and third trimesters. The coordination of MIP and ANC services between the National Malaria Control Program (NMCP) and maternal/reproductive health programs is still weak despite some efforts by the Ministry of Health (MOH). The national working group focused on maternal and child health is the coordination body between these two programs.

Case Management: Burundi's malaria treatment guidelines require diagnostic confirmation of all fever cases, either by rapid diagnostic test (RDT) or microscopy, before treatment with an artemisinin-based combination therapy (ACT). Burundi's policies, guidelines, and practices are consistent with WHO recommendations. The national malaria treatment guidelines changed in 2019, recommending the use of RDTs for all cases at the community, health center, and hospital levels. Microscopy testing is recommended at health centers and hospitals for patients presenting malaria symptoms 28 days after a correct malaria treatment. Health centers refer severe cases to both national and regional hospitals. The new treatment protocol recommends the use of AL at all levels.

Community testing and treatment of malaria for children under five years of age was introduced in 2013. The new treatment protocol for iCCM includes pre-referral rectal artesunate for children under five years of age presenting with symptoms of severe malaria. The NMCP also adopted PECADOM in 2021 as a national strategy, with 21 districts currently integrating the strategy and a plan for expansion pending availability of funding.

Community health workers (CHWs) are an integral part of Burundi's health system. In the calendar year 2020, there were 4,920 CHWs implementing iCCM among the 13,374 CHWs of all cadres (some of which are limited to health promotion activities) identified by the MOH. These CHWs are reporting to health centers and are supervised by the health promotion technicians; each CHW is covering an average of 500 children under five years of age for iCCM intervention, representing 40 percent of the targeted population. The iCCM strategy is implemented in 42 out of the 49 health districts of the country. The community performance-based financing, which was started in 2018, is the mechanism used to incentivize the CHWs. Currently, performance-based community financing covers 13 of the country's 18 provinces (the five non-covered provinces are Bujumbura mairie, Bujumbura, Bururi, Rumonge, and Rutana). The goal is to cover all provinces.

Pharmaceutical management: The NMCSPP (2022–2027) highlights the objective of strengthening the commodities quantification process and improving commodities storage and management at central, district, and facility levels. This objective is also linked with achieving the case management objectives outlined in the NMCSPP. The Burundian Regulatory Authority for Medicines for Human Use and Food (*Autorité Burundaise de Régulation des Médicaments à Usage Humain et des Aliments* or ABREMA) is the division of the MOH charged with regulations and oversight of the pharmaceutical sector. The ABREMA also regulates the semi-autonomous central purchasing and warehousing agency, the *Centrale des Achats des Médicaments Essentiels du Burundi* (CAMEBU) in line with national pharmaceutical policy. CAMEBU is responsible for the procurement and management of public sector pharmaceuticals

destined for public health and faith-based health facilities through a push distribution system. However, community health systems are not well integrated in the existing supply chain and data management systems.

The MOH has selected an end-to-end electronic logistics management information system (eLMIS) solution (software) with an objective to be operational within 2022–2024.

Social and behavior change (SBC): SBC is an important component of malaria prevention and control activities and is crucial to achieving ITN coverage and use objectives. A national communication strategy for malaria was developed in 2014. The strategy aimed to further raise awareness in the general population and increase adoption and maintenance of behaviors related to malaria prevention and treatment. The NMCP implements SBC activities using channels such as radio, print material, theater groups, and community outreach, and is focused on increasing uptake of malaria services, including correct and consistent use of ITNs, prompt care-seeking for fever, and early and frequent ANC attendance to increase uptake of IPTp among pregnant women. Due to the COVID-19 pandemic, community interventions have been limited in 2020 and 2021. These interventions need to be improved in 2022, combined with the active engagement of civil society and community organizations and leaders.

Surveillance, monitoring, and evaluation: The NMCP Monitoring and Evaluation Plan (2018–2023) is aligned with the NMCSP 2018–2027. It recognizes the need to strengthen monitoring and evaluation of malaria control interventions, activities, policies, and strategies and ensure that decisions are made using available evidence, including strengthening of entomological monitoring, to control the epidemic. Malaria program data is collected through the Burundi department of statistics using the DHIS2 deployed nationwide. The reporting of health data is done on a daily basis via registers at health centers, and these data are then transcribed into the DHIS2 by the head of the health centers. The data from the community level are consolidated and integrated on a monthly basis.

Despite the presence of functioning DHIS2 software in the country, data collection and use for decision-making remains a challenge at all levels of the health system. With the support of USAID, the malaria surveillance monitoring and evaluation technical working group is functioning with four meetings held on a quarterly basis. USAID supported the production of quarterly malaria bulletins for simplified data use.

OTHER CONTEXTUAL INFORMATION

Burundi emerged from over a decade of protracted civil war in 2000, with the signing of the Arusha Peace Accord. Burundi's first democratic election after the civil war was held in 2005. However, Burundi faced a new upsurge of political instability and violence in

2015 brought on by a disputed election. The repercussions are still being felt at the socio-economic level, affecting households' financial access to health care and food.

Burundi is highly vulnerable to humanitarian shocks resulting from recurrent floods, recurrent epidemics, and displacement of populations, including refugees, returnees, and internally displaced persons (IDPs). Heavy rainfall causing widespread flooding and landslides, and rain insufficiency in the northeastern and eastern provinces, are the primary drivers of internal displacement in Burundi, adversely affecting up to 50,000 people in any given rainfall season. The International Organization for Migration cited approximately 113,408 IDPs, of which 83 percent were affected by natural disasters. Since September 2017, over 190,000 Burundians returned through the joint Government of Burundi-United Nations High Commissioner for Refugees voluntary repatriation exercise yet nearly 263,000 Burundian refugees, many of whom fled the 2015 political violence, still remain in regional countries as of January 2022. The Government of Burundi actively promotes refugee returns, but this strains provincial and local government resources, and returnees face food insecurity and other reintegration challenges upon return to their communities. Burundi hosts more than 75,000 refugees and asylum-seekers, primarily from the Democratic Republic of the Congo, resulting from civil strife dating back to 2006.

In terms of gender norms, men's dominant role in household decision-making may result in men selling the bed nets without women's permission and may limit women's ability to make decisions regarding malaria prevention for them and their children. This is anecdotal however, as gender issues regarding net use were not covered in the 2018 knowledge attitudes practice survey.

III. NMCP STRATEGIC PLAN

The National Malaria Strategy is aligned with WHO strategy along two objectives: 1) Reduce malaria-related morbidity by at least 60 percent by 2027, and 2) Reduce malaria-related mortality to zero by 2027 with 11 specific objectives (listed below) and seven strategic focus areas.

1. Achieve and maintain universal household coverage of ITNs and achieve at least 80 percent utilization rate in the general population by 2027.
2. Ensure and maintain coverage of at least 95 percent of IRS in targeted areas.
3. Ensure that at least 80 percent of pregnant women are covered by IPTp according to the national guidelines by 2027.

4. Ensure that 100 percent of suspected malaria cases received in health facilities are treated in accordance with national policy by 2027.
5. Ensure that 100 percent of suspected malaria cases are managed at the community level by 2027, in accordance with national policy.
6. Ensure that at least 90 percent of health facilities and CHWs have a continuous supply of antimalarials by 2027.
7. Ensure that at least 80 percent of the population adopts malaria control behaviors by 2027.
8. Strengthen the managerial, technical, and institutional capacities of the NMCP at all levels by 2027.
9. Ensure that the NMCP has sufficient human, material, and logistical resources at for the monitoring and evaluation of malaria interventions by 2027.
10. Capture, analyze, and disseminate at least 95 percent of malaria data including research results for decision making by 2027.
11. Ensure 100 percent early detection of malaria epidemics by 2023 and control 100 percent of epidemics detected within two weeks by 2027.

Major innovations in the national malaria strategy plan are as highlighted below:

- Extension of community-based health services by 2026: In order to increase access to health services, community-based care will be extended from nine in 2022 to 28 health districts for all ages through PECADOM and for children under five years of age through iCCM from 42 health districts in 2022 to 46 health districts (all health districts in the country excluding the three districts of Bujumbura). The emphasis will be put on high quality service, and increased access to malaria commodities for CHWs by strengthening the supply chain system at community level.
- Strengthening entomological surveillance by 2026: Nine additional sentinel sites will be set up with the support of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), in addition to the USAID-supported nine sentinel site already operating, to ensure coverage of all the country's geo-epidemiological zones.

IV. KEY MALARIA DATA

EVOLUTION OF KEY SURVEY-BASED MALARIA INDICATORS

Table 3: Key Survey Indicators

Indicator	2010 DHS	2012 MIS	2016–17 DHS
% Households with at least one ITN	52.0	63.0	46.2
% Households with at least one ITN for every two people	23.5	25.5	17.1
% Population with access to an ITN	39.1	46.0	32.3
% Population that slept under an ITN the previous night	37.8	48.6	34.7
% Children <5 years of age who slept under an ITN the previous night	45.0	53.8	39.9
% Pregnant women who slept under an ITN the previous night	49.7	56.1	43.9
% Children <5 years of age with a fever in the last two weeks for whom advice or treatment was sought	65.8	58.7	69.6
% Children <5 years of age with a fever in the last two weeks who had a finger or heel stick	27.0	28.3	66.4
% Children receiving an ACT among children <5 years of age with a fever in the last two weeks who received any antimalarial drug	12.0	18.0	5.3
% Women who attended 4 ANC visits during their last pregnancy	33	N/A	49
% Women who received three or more doses of IPTp during their last pregnancy in the last two years	0.0	0.1	12.6
Children <5 years of age mortality rate per 1,000 live births	96 (88-105)	N/A	78 (71-85)
% Children <5 years of age with parasitemia by microscopy	N/A	17.0	27.0
% Children <5 with parasitemia by RDT	N/A	22.0	38.0

DHS: Demographic and Health Survey; MIS: Malaria Indicator Survey

Figure 5. ITN Use:Access Ratio Map

Map based on data from the 2016-2017 DHS shows that the ratio of ITN use to access use in Burundi is very high, ranging between 0.83 in Bururi to 1.21 in Karusi. It should be noted, however, that this high use:access ratio is calculated from both low access (32 percent) and low use (35 percent). While there is a need to increase access to ITNs, the low overall percentage of household members using an ITN indicates a need for strong SBC activities promoting net use to accompany efforts to increase ITN access.

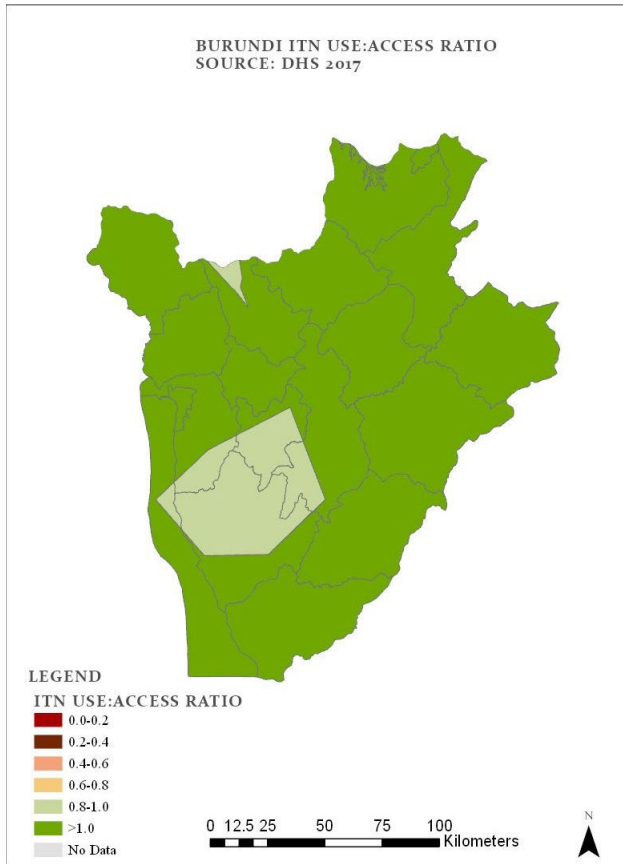


Table 4: Evolution of Key Malaria Indicators Reported through Routine Surveillance Systems

Indicator	2017	2018	2019	2020	2021
# All-cause patient consultations	19,579,920	18,527,521	23,217,505	20,604,736	21,941,937
# Suspect malaria cases ¹	N/A	N/A	N/A	N/A	na N/A
# Patients receiving diagnostic test for malaria ²	11,868,543	10,350,401	15,187,477	10,501,521	12,328,863
Total # malaria cases ³	7,666,945	5,654,535	9,739,929	5,383,129	6,758,569
# Confirmed cases ⁴	7,659,618	5,648,749	9,720,860	5,363,503	6,753,290
# Presumed cases ⁵	7,327	5,786	19,069	19,626	5,279
% Malaria cases confirmed ⁶	99.9	99.9	99.8	99.6	99.9
Test positivity rate (TPR) ⁷	64.5	54.6	64.0	51.0	44.2
Total # children <5 years of age malaria cases ⁸	4,000,848	2,648,215	4,472,015	2,601,527	2,951,271
% Cases in children <5 years of age ⁹	51.4	45.9	66.6	41.6	43.7
Total # severe cases ¹⁰	59,148	36,527	399,244	282,303	300,007
Total # malaria deaths ¹¹	4,253	2,738	3,525	2,977	2,516
# Facilities reporting ¹²	1,173	1,152	1,158	1,155	1,171
% Data completeness ¹³	94.2	93.8	93.7	98.2	99.5

1 Suspected malaria cases are not reported by the health system. At this point, Burundi can only provide “Number of patients with a fever and tested by RDT or microscopy”; 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 Severe cases are defined as an acute form of malaria accompanied by signs of severity and/or dysfunction of vital organs; 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	1,556,043	454,659	595,421
Total # of malaria cases reported by CHWs ¹	1,233,303	328,793.	468,288
% of CHW reported cases (among total malaria cases) ²	12.7	6.1	6.9

1 Includes all ages, confirmed and unconfirmed.

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

V. OTHER IMPLEMENTATION INFORMATION

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 (%)
Kirundo (PermaNet 3.0)	Baseline:	16.0	84.0 (N=300)	100.0
	7.8	27.2	72.8 (N=246)	100.0
Muyinga (Yorkool)	Baseline:	20.9	79.1 (N=235)	100.0
	7.8	33.6	66.4 (N=217)	100.0
	12m: 13.4			

Standard ITN durability monitoring is ongoing and the conclusion will be presented at the end of the monitoring activity in December 2022. Preliminary results suggested a concerning level of attrition. The country and Vectorlink decided to discontinue the 36-months data collection due to potential bias in the endline study given that there will be new nets distributed in 2022 through the mass distribution campaign, six months prior to the end of monitoring.

Table 7: Summary of Completed Therapeutic Efficacy Studies (Non-USAID-Funded)

Year	Site	Treatment arm(s)	Efficacy (PCR-corrected adequate clinical and parasitological result) for each drug at each site
2018	Mutoyi, Kigobe, Buhiga, and Kazirabageni	ASAQ, AL	Kigobe: 97.1% Mutoyi: 92.3% Buhiga: 93.2% Kazirabageni: 92.7%
2021*	Buhiga (Karusi), Mutoyi (Gitega) et Kigobe (Mairie de Bujumbura)	AL	Kigobe: 97.5% Mutoyi: 94.3% Buhiga: 80%

*Preliminary result without polymerase chain reaction (PCR) correction

VI. KEY POLICIES

Table 8: Policies in Burundi

National Malaria Strategic Plan (2021–2027)	
National Surveillance Monitoring and Evaluation Plan (2018–2023)	
National Digital Health Strategy (2020–2024)	
National Communication Strategy (2018–2023)	
National Supply Chain Strategy/Master Plan (2021–2025)	
National Vector Control Strategy and Integrated Vector Management Plan (published 2019)	
Malaria Case Management Policy (published 2019)	
What is/are the first-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*?	AL
What is/are the second-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*?	Dihydroartemisinin + piperazine (these drugs are not available in the country, Alternative quinine)
What is the first-line treatment for severe malaria?	Injectable artesunate

In pregnancy, what is the first-line treatment for uncomplicated <i>P. falciparum</i> malaria in the <u>first trimester</u> ?	Quinine+ clindamycine. (This is what is recommended, but in practice, quinine alone is used.)
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> ?	AL
In pregnancy, what is the first-line treatment for severe malaria?	Injectable artesunate (policy currently recommends injectable quinine for the first trimester. USAID is working with the MOH to update this policy).
Is pre-referral treatment of severe disease recommended at peripheral health facilities? If so, with what drug(s)?	Injectable artesunate
Is pre-referral treatment of severe disease with rectal artesunate recommended for community health workers?	Rectal artesunate suppository
What is the # of CHWs currently providing iCCM?	4,920
What is the country's target for the number of CHWs providing iCCM?	No target set, the rationale for iCCM is one CHW per <i>subcolline</i> and the current plan is to expand iCCM from 42 to 46 health districts.
What percent of the country's target is met?	40 out of the 49 districts covered (1 CHW per <i>subcollines</i> regardless of the size of households) .
Does the country have a policy that enables the routine, regular payment of salaries/stipends for CHWs?	Yes, performance-based financing.
Do CHWs have the authority to test and treat all ages for malaria?	Yes, in limited settings with plans for expansion.
Prevention of malaria in pregnancy policy Published 2014	
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?	Week 13

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?	No, 4 ANC contacts are recommended.
What is the status of training ANC providers on the WHO recommended 8+ contacts?	Providers are not trained.
Have HMIS/DHIS2 and ANC registers been updated to include 8+ contacts?	No
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?	Data are collected as single months.
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?	No

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 18 provinces 	<ul style="list-style-type: none"> National for ITN campaign IRS in four (Muyinga, Gashoho, Buye, Kiremba health districts out of the 49) iCCM + PECADOM in 9 health districts out of the 49 National for MIP National for case management 	\$65,600,000	Current grant covers 2021 to 2023
Government of Burundi	<ul style="list-style-type: none"> Procure 10% of RDT and ACT national needs Implement case management at facility and community Organize training and supportive supervision at least once a year in 18 provinces 	<ul style="list-style-type: none"> National 	N/A	Annually
World Vision International	<ul style="list-style-type: none"> IRS 	<ul style="list-style-type: none"> IRS in two districts (Murore and Cankuzo) out of the 49 	N/A	2022–2024
UNICEF	<ul style="list-style-type: none"> iCCM in seven provinces Supportive supervision 	Seven out of 18 provinces (Gitega, Kirundo, Ngozi, Cibitoke, Bubanza, Ruyigi, and Kayanza)	N/A	Annual

Partner	Key technical interventions	Geographic coverage	Funding amount or in-kind contribution	Timeframe
<i>Médecins Sans Frontières</i> Belgium	<ul style="list-style-type: none"> Testing and treatment in Kinyinya and Ryansoro health districts. 	Testing and treatment at districts hospital	N/A	2015 - Ongoing