

COTE D'IVOIRE 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. Côte d'Ivoire began implementation as a PMI focus country in FY 2018. Please see the [Côte d'Ivoire Malaria Operational Plan](#) for more information on PMI's approach and investments.

II. CONTEXT

As Côte d'Ivoire transitions into an emerging economy, the country continues to face significant health challenges, including malaria, which is the leading cause of mortality among children and continues to be the top reason for medical consultations and hospitalizations.

There were more than 6.4 million presumed and confirmed malaria cases in the general population and 2.6 million presumed and confirmed malaria cases in children under 5 years of age reported from health facilities in 2021 (District Health Information Software 2 [DHIS2]).

Malaria is endemic throughout Côte d'Ivoire the entire year, with peaks during the rainy season from April to July.

The health system in Côte d'Ivoire comprises an administrative element and a care element, which are interdependent. Each has three levels, which play specific roles in malaria control. The National Malaria Control Program (NMCP) sits at the central level, which is overseen by the Minister of Health. The intermediate level represents 33 regional health departments, each of which covers several health districts, which oversee all private, public, and community-level health services within their respective health regions. The peripheral level consists of 113 health districts, which are responsible for all the public and private health services within the area it covers. The districts are responsible for the operational implementation of the national health policy.

The community sector helps to support the public sector, although it has only recently been formalized. The government is working to reinforce community case management for home-based case management in children under 5 years of age.

The current 2021–2025 National Malaria Control Strategy (2021-2025 NMSP) in Côte d’Ivoire aims to reduce malaria morbidity and mortality by increasing the proportion of the population sleeping under an insecticide-treated mosquito net, of pregnant women taking sulfadoxine-pyrimethamine (SP), and of malaria cases, which are confirmed and treated in accordance with national guidelines. The strategy includes an emphasis on introducing an integrated approach to community interventions (malaria, pneumonia, and diarrhea) and a more participative and inclusive role for the private sector in combating malaria. In line with the Global Technical Strategy for Malaria Control 2016–2030, the objectives of this strategic plan are:

- By the end of 2025, reduce malaria mortality rates by at least 75 percent compared to 2015.
- By the end of 2025, reduce the incidence of malaria cases by at least 75 percent compared to 2015.
- By the end of 2025, strengthen and sustain the program's management, coordination, and partnership capacities to achieve performance at all levels.

Table 1: General Demographics and Malaria Situation

Population	27,087,733 (Estimation of the National Institute of Statistics, 2021)
Population at risk of malaria	100 percent of the whole population
Malaria prevalence	37.1 percent (Parasite prevalence survey of malaria and anemia in Côte d'Ivoire/ <i>Enquête de prévalence parasitaire du paludisme et de l'anémie</i> [EPPA], 2016)
Malaria incidence/1,000 population at risk	173.43 (Annual Health Statistics Report/ <i>Rapport Annuel de la Situation Sanitaire</i> [RASS] 2020, 2020)

STRATIFICATION

In Côte d’Ivoire, a stratification exercise was conducted in 2019, during a workshop with the *Groupe Scientifique d’Appui*, a group of scientists, and vector control key stakeholders. This exercise was based on the findings from entomology surveillance studies.

PMI has supported vector control activities in the NMSP since 2018. PMI’s support has contributed to the generation of entomological and insecticide resistance data that allowed the NMCP to conduct a stratification of vector control interventions. As a result, PMI contributed 2.9 million pyrethroid-piperonyl butoxide (PBO) insecticide-treated mosquito nets (ITNs) to distribute in 11 districts in April 2021 during the mass distribution campaign. The PMI-funded 2.9 million nets as well as the 16 million other nets procured by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) were selected based on stratification data.

Table 2: Malaria Parasites and Vectors

Principle Malaria Parasites	Plasmodium falciparum
Principle Malaria Vectors*	Anopheles gambiae s.l., An. coluzzii, and An. funestus s.l.
Peak malaria transmission	April - June

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

Figure 1: Vector Control Activities

The map below shows vector control activities in Côte d'Ivoire. Entomological monitoring was conducted in 18 sites and indoor residual spray (IRS) implementation in two districts: Nassian and Sakassou. ITN distribution was based on insecticide susceptibility stratification: standard bed nets distributed in 84 districts, PBO nets in 11 districts, and dual active ingredient insecticide-treated nets (G2) nets in 18 districts.

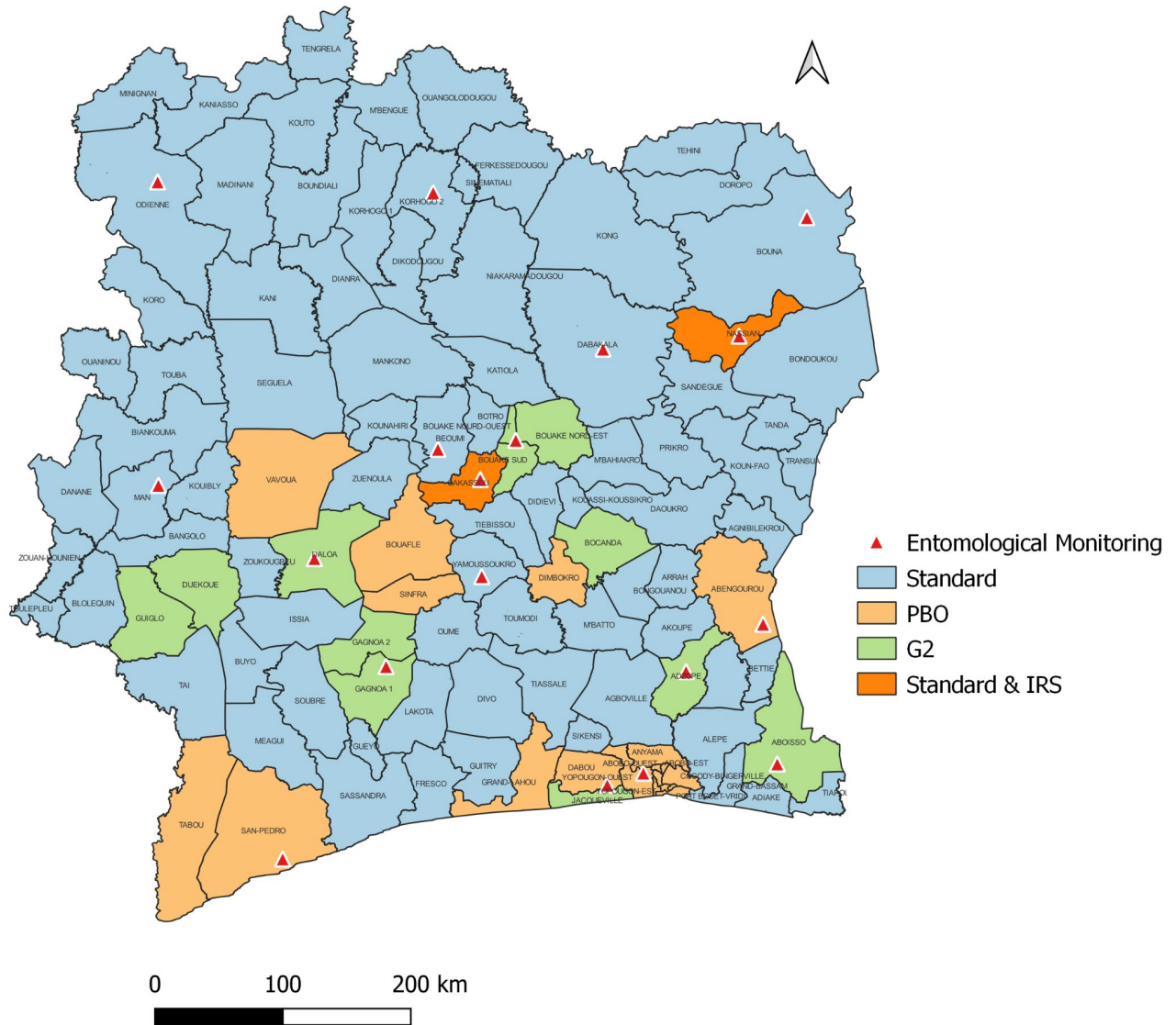
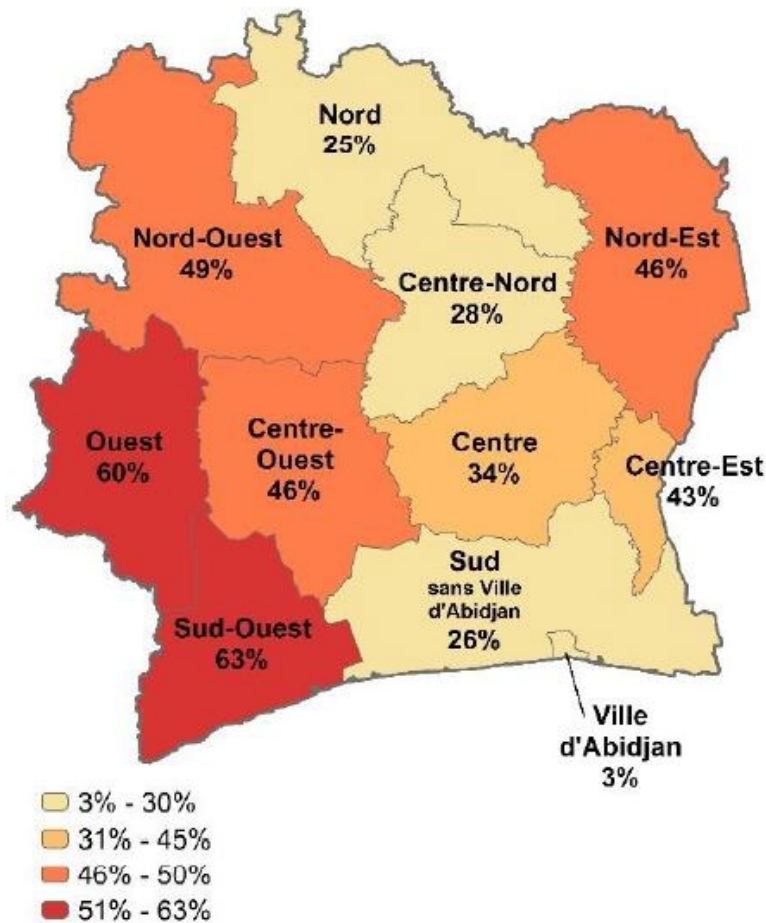


Figure 2: Malaria Prevalence By Geographic Area for Children 6 to 59 months of age who tested positive for malaria by microscopy

Figure 2 illustrates the malaria prevalence per region and per microscopy test result. The data shows a higher prevalence than elsewhere in the southwest (63 percent) and west (60 percent) and, in contrast, a significantly lower prevalence in the north central (28 percent), north (25 percent), and especially in the city of Abidjan, which has a prevalence of 3 percent. Cote d'Ivoire had not conducted any major surveys recently. The 2021 DHS is still in process and results are expected in the near future after which most recent data will be available.

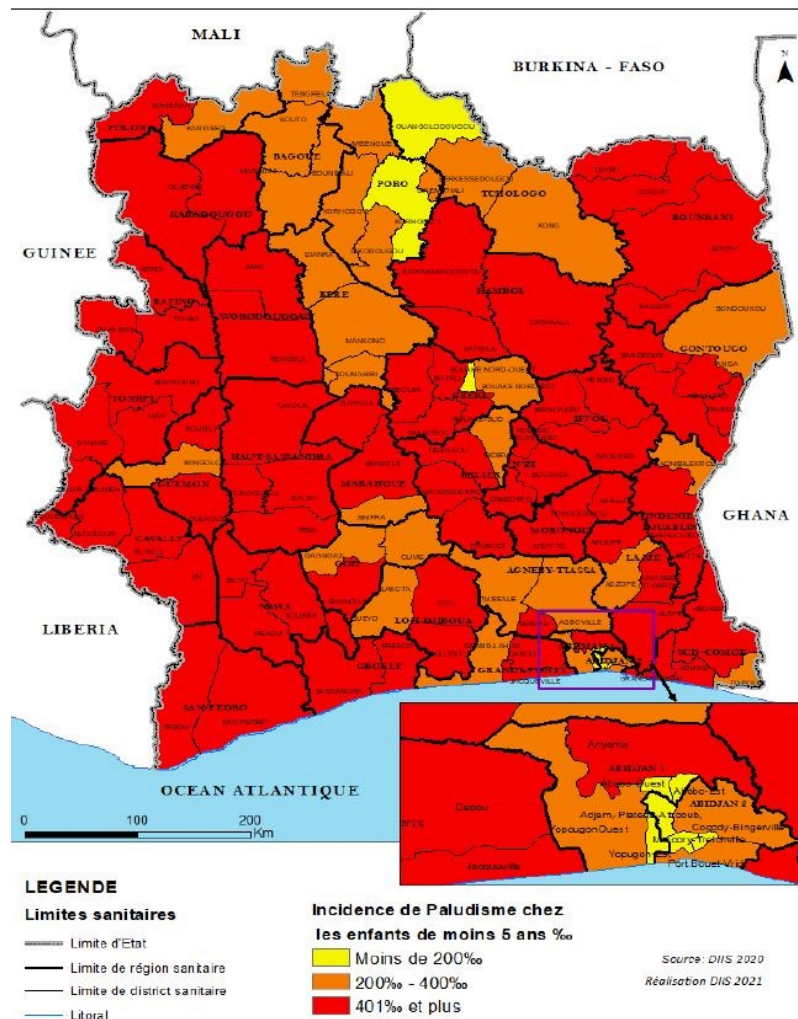


Source: EPPA, 2016

Figure 3: Malaria Incidence for Children under 5 Years of Age by Health Region In 2020

Figure 3 shows the incidence rate by health region for children under 5 years of age. The health regions that recorded the highest incidences of malaria for children under 5 years of age were Cavally (805.46/1,000), Gboklé (780.41/1,000), and Bafing (745.66/1,000).

The lowest incidences for children under 5 years of age are recorded in Abidjan 2 with 165.22/1,000, Abidjan 1 with 183.28/1,000 and Poro with 216.08/1,000.



Source: RASS, 2020

Geography and Climate

Côte d'Ivoire is located in West Africa on the Gulf of Guinea (Atlantic Ocean). Its surface area is 322,462 km². The country borders Ghana to the east, Burkina Faso and Mali to the north, and Guinea and Liberia to the west.

Côte d'Ivoire has a tropical climate with four seasons in the coastal and central regions and two seasons in the northern savannah region. The northern region has a long dry season from November to May and a wet season from June to October. The coastal and central regions have:

- A long dry season from December to May
- A long rainy season from May to July
- A short dry season from July to October
- A short rainy season from October to November

COTE D'IVOIRE HEALTH SYSTEM

The health system in Côte d'Ivoire comprises an administrative element and a care element, which are interdependent. Each has three levels, which play specific roles in malaria control. The central level, which is overseen by the Minister of Health, comprises the Cabinet, two general directorates, nine central directorates, 14 national public health institutes and 24 coordination departments for the national health programs, including the NMCP. This level is responsible for defining health policy, general coordination of the health care system, resource mobilization, monitoring and evaluation, and operational research. In terms of care services, the central level is made up of five university hospitals, five specialized institutions, five national public institutes, and the medical emergency hospital. These care services provide not only treatment for severe malaria cases but also intermittent preventive treatment of malaria for pregnant women (IPTp), routine distribution of ITNs, and conducting of malaria-related operational research.

The intermediate level represents 33 regional health departments, each of which covers several health districts, which oversee all private, public, and community-level health services within their respective health region. The peripheral level comprises 19 regional hospitals, 100 general hospitals, and two specialized hospitals, which provide treatment for both uncomplicated and severe malaria cases, IPTp, and routine distribution of ITNs. The regional level hospitals serve as the first referral site for medical services that are unavailable at district level hospitals. The peripheral level consists of 113 health districts, which are responsible for all the public and private health services within the area it covers. Each health district is administered by a district

management team (*équipe cadre de district* or ECD) led by the departmental director. The ECDs are responsible for the operational implementation of the national health policy. They monitor and supervise providers' application of malaria control guidelines and are responsible for collecting and submitting health data on malaria from the health facilities to the central level. The public sector comprises 2,311 health facilities (*établissements sanitaire de premier contact* or ESPC) and a total of 1,100 private ESPCs. Each ESPC is managed by a qualified health professional (i.e., a medical doctor, specialized nurse or midwife). The ESPCs provide routine case management for uncomplicated malaria; IPTp; and routine distribution of ITNs to pregnant women during their first antenatal care (ANC) visit, to children under one year of age during immunization visits, and to children between 1 and 5 years of age during health child consultations. Severe malaria cases are referred to district-level hospitals. The public sector consists of 4,435 doctors (3,715 doctors health care providers), 12,994 nurses (12,471 nurses working in health care services), and 6,744 midwives (6,495 midwives/health care providers). Based on the total population in 2020 of an estimated 26,453,542, the ratio of public-sector health care workers to the population is as follows: 1 doctor per 7,121 inhabitants, 2.36 nurses per 5,000 inhabitants, and 3.05 midwives per 3,000 women of childbearing age. Côte d'Ivoire currently exceeds its standard for nurses and midwives.¹ An estimated 70.19 percent of the population lives at least 5 km from the nearest health facility. The private health sector consists of 1,046 for-profit private health centers providing a range of services, including treatment of malaria (RASS, 2020)². The NMCP is in the process with these private health facilities, of providing a package of malaria-prevention activities that include free SP to pregnant women, ITNs during ANC and to children under 1 year of age, trainings to improve diagnosis and treatment, and social and behavior change activities targeting patients and health care workers. Discussion is ongoing with them for their full participation in the national reporting process.

The community sector helps to support the public sector. The Government of Côte d'Ivoire (GOCI) is working to reinforce community case management for home-based case management in children under 5 years of age, which is primarily led by non-governmental organization (NGOs).

In 2018, the country adopted a national community health strategic plan with the aim of making community health an important component of the health system.

¹ The standards for the health human resources are: one doctor per 10,000 inhabitants; one nurse per 5,000; one midwife per 3,000 women of childbearing age.

² RASS, 2020.

Routine Health Information System (RHIS)

DHIS 2 was established by the Ministry of Health (MOH) as the national platform for the Health Information System and it covers all the health regions and districts collecting, analyzing and disseminating routine health data. Despite combined efforts from the MOH's Division in charge of the Health Information Management System (HMIS) and the NMCP, data quality remains an important challenge that PMI, the Global Fund, and other partners are joining hands to support the country's needs.

SUPPLY CHAIN MANAGEMENT

Like most PMI countries, there are significant challenges and needs related to supply chain strengthening activities. These challenges include:

- Low reporting rates on stock status and/or delays in reporting.
- Weak inventory management systems at district and health facility level.
- Ineffective management and recurring stock outs of laboratory commodities.
- Inadequate “last mile” commodity distribution planning.
- Unsatisfactory storage conditions at most district and health facility pharmacies.
- Irregular collection and disposal of wasted, expired, damaged, or unused products.

The national health care supply chain system is led by three entities. The GOCI National Pharmaceutical Agency (*Programme National de Développement de l'Activité Pharmaceutique*) develops and enforces health supply chain policy and develops supply chain standard operating procedures for the health supply chain. The GOCI National Medicines Authority (*Direction de la Pharmacie, du Médicament et des Laboratoires*) is responsible for the registration of pharmaceuticals and for the approval of health products. The *Nouvelle Pharmacie de Santé Publique* (NPSP) acts as the Central Medical Stores and is a nonprofit NGO under contract with the GOCI to manage all implementation aspects of the public sector health care supply chain. In this regard, NPSP functions as the primary procurement agency for the GOCI health commodity supply chain.

In 2013, USAID helped the GOCI to further decentralize the health care supply chain to increase access to and ensure continuous availability of essential medicines and pharmaceutical products at service delivery points. Decentralization meant that districts would have greater autonomy and authority over their supply chain activities. The districts were delegated responsibility for storeroom and stock management and

organization. NPSP operates a central warehouse in Abidjan and as part of an overall strategy of decentralization is planning to open a regional warehouse in Bouaké in 2022 with three additional warehouses planned for Korhogo, Abengourou, and Gagnoa. NPSP is responsible for reception, storage of health products, and supply and delivery to districts with districts then responsible for supply and delivery to hospitals and health centers.

Each of the country's 33 health regions has a pharmacist who is tasked with overall supply chain management for the region. Responsibilities include commodity needs forecasting, inventory, staff training, and Logistics Management Information System (LMIS) reporting. The regional pharmacists also monitor the performance of district pharmacies within their respective regions. Each of the health districts has a district pharmacist who executes similar supply chain management activities within the district, including coordinating the distribution of commodities to health facilities. The commodities required to support national health programs are either procured by the NPSP or provided by donor organizations, various health partners, and other in-country stakeholders.

The GOCI developed a paper-based LMIS in 2007, which is still in use. The LMIS never reached full functionality and the data that NPSP has on hand does not reflect the actual status of the supply chain. Furthermore, LMIS data vary significantly across disease programs, particularly for HIV, malaria, TB, and essential medicines. In July 2013, the MOH decided to transition from a paper-based to an electronic LMIS (eLMIS). Following a successful USAID-supported pilot of eLMIS in 2016 in 14 regions, the system will now be expanded to all regions in Côte d'Ivoire. As of today, the eLMIS is rolled out in all the 373 eligible health facilities.

OTHER CONTEXTUAL INFORMATION

Côte d'Ivoire is ranked 162nd out of 189 countries in the 2019 Human Development Indicators. Between 1990 and 2019, Côte d'Ivoire's ranking rose from 0.404 to 0.538 (an increase of 33.2 percent). The poverty rate is 51.2 percent (2019), with disparities between urban and rural areas: the poverty rate in urban areas is 29.5 percent, while in rural areas it is 62.5 percent. There are also gender disparities in poverty.

Côte d'Ivoire has a Gender Integrated Index of 0.638, which places it 153 out of 162 countries in the 2019 index. In Côte d'Ivoire, 13.3 percent of parliamentary seats are held by women and 17.9 percent of adult women have attained secondary education, compared to 34.4 percent of men. Out of 100,000 live births, 617 women die of pregnancy-related causes and the teenage fertility rate is 117.6 births per 1,000 women 15 to 19 years of age. The female activity rate is 48.2 percent, against 65.5 percent for men.

The GOIC adopted the National Policy for Equal Opportunity, Equity and Gender (*Politique nationale de l'égalité des chances, l'équité et le genre*) in 2009 to promote gender equality and subsequently implemented various activities.

In addition, there are various ethnic groups in Côte d'Ivoire, each with a different language, culture and customs, and the social status of women is different in each group. For example, the Akan are matrilineal and women hold a high social position, and there are female village chiefs. However, generally, the social and economic position of women in Côte d'Ivoire is low, and their access to social services and economic power is inferior to that of men.

Concerning the displaced population context in Côte d'Ivoire, despite political tensions and social unrest in its past, Côte d'Ivoire has kept its borders open to those seeking protection. Recently, there have been a greater number of refugees leaving Côte d'Ivoire than entering. As of January 31, 2022, there were 2,209 refugees and 1,401 asylum seekers in Côte d'Ivoire ([UNHCR operational portal](#)). Côte d'Ivoire is not eligible to include the displaced population in PMI Malaria Operational Plan 2023; the country will not specially target the displaced population in this operational plan 2023. As a reminder, there are two criteria to be eligible to target the displaced population in PMI Malaria Operational Plan : (i) Countries where PMI operates and (ii) Refugee/internally displaced person population greater than 10,000 at the time of application.

III. NMCP STRATEGIC PLAN

In line with the World Health Organization's Global Technical Strategy for Malaria Control 2016-2030, the NMCP Strategic Plan 2021-2025 (NSP 2021-2025) objectives are:

- By the end of 2025, reduce malaria mortality rates by at least 75 percent compared to 2015.
- By the end of 2025, reduce the incidence of malaria by at least 75 percent compared to 2015.
- By the end of 2025, strengthen and maintain the program's management, coordination, and partnership capacities to achieve performance at all levels.

This NSP 2021–2025 is supported by the social and behavior change communication activities which have the following objectives:

- At least 90 percent of the population is aware of national malaria prevention measures by 2025.

- At least 90 percent of the population have a good knowledge of the signs of malaria by 2025.
- At least 80 percent of the population are practicing malaria prevention correctly by 2025.
- At least 80 percent of the population sleep under an ITN by 2025.
- At least 80 percent of children under 5 years old sleep under an ITN by 2025.
- At least 80 percent of pregnant women sleep under an ITN by 2025.
- At least 80 percent of disaster-affected populations benefit from specific malaria prevention measures (ITNs, IPT for pregnant women and IPT) by 2025.
- At least 85 percent of household heads in target areas have adhered to indoor residual spraying.
- At least 60 percent of households in target districts conduct a monthly sanitation campaign by 2025.

IV. KEY MALARIA DATA

EVOLUTION OF KEY SURVEY-BASED MALARIA INDICATORS

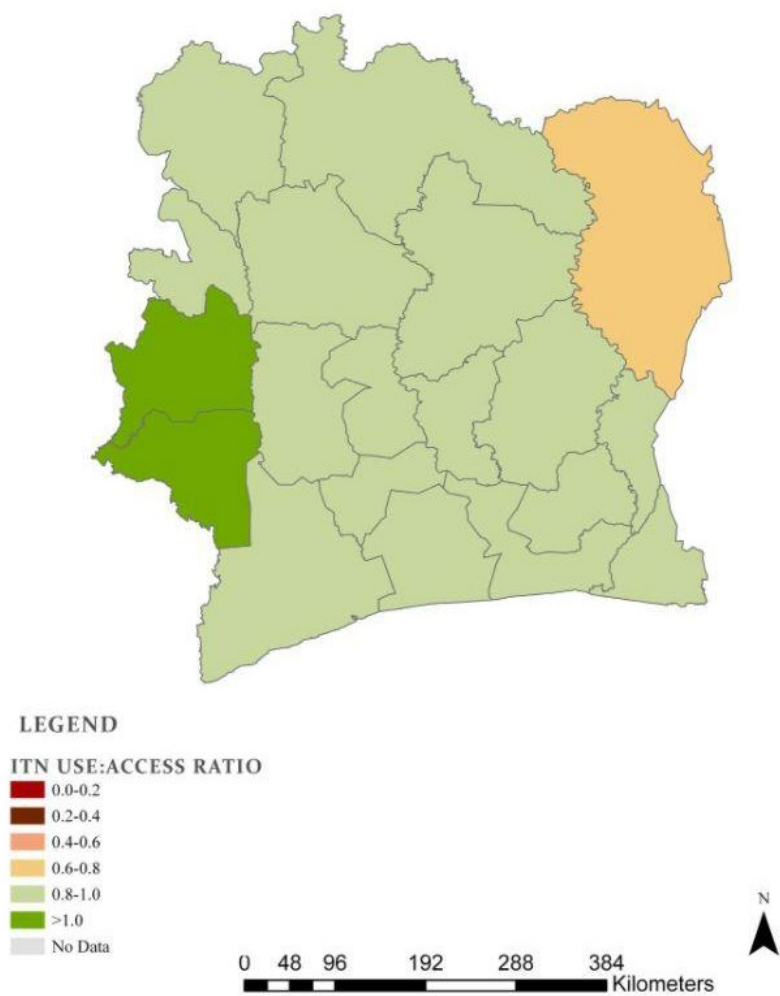
Table 3: Key Survey Indicators

Indicator	2012, EDS-MICS*	2016, MICS**
% Households with at least one ITN	67	75.8
% Households with at least one ITN for every two people	31.7	47.3
% Population with access to an ITN	49	27.1
% Population that slept under an ITN the previous night	33	50.5
% Children <5 years of age who slept under an ITN the previous night	37.2	59.7
% Pregnant women who slept under an ITN the previous night	40.2	53.4
% Children <5 years of age with a fever in the last two weeks for whom advice or treatment was sought	42.8	45.2
% Children <5 years of age with a fever in the last two weeks who had a finger or heel stick	11	18.1
% Children receiving an ACT among children <5 years of age with a fever in the last two weeks who received any antimalarial drug	17.4	11.5
% Women who attended 4 ANC visits during their last pregnancy	44.2	51.3
% Women who received three or more doses of IPTp during their last pregnancy in the last two years	20	22.6
<5 mortality rate per 1,000 live births	108	96
% Children <5 with parasitemia by microscopy	18	37.1
% Children <5 with parasitemia by RDT	41.5	47.7

DHS: Demographic and Health Survey; EDS: *Enquête Démographique et de Santé et à Indicateurs Multiples*; MICS: Multiple Indicator Cluster Survey; MIS: Malaria Indicator Survey

* EDS, 2011-2012; ** MIS 2016

Figure 4: ITN Use:Access Ratio Map



Source: MICS, 2016

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

Indicator	2017	2018	2019	2020	2021
# All-cause patient consultations	12,538,009	13,119,014	14,043,455	13,676,261	14,387,357
# Suspect malaria cases ¹	6,448,261	7,147,273	8,283,048	7,434,699	8,613,027
# Patients receiving diagnostic test for malaria ²	5,670,119	6,189,216	7,601,761	5,848,660	8,061,537
Total # malaria cases ³	4,774,667	4,780,174	4,811,546	4,808,565	6,838,891
# Confirmed cases ⁴	4,261,641	4,777,031	5,935,011	4,586,397	6,126,243
# Presumed cases ⁵	NA	NA	NA	NA	340,852
% Malaria cases confirmed ⁶	89%	100%	123%	95%	85%
Test positivity rate (TPR) ⁷	75%	77%	78%	78%	71%
Total # children <5 years of age malaria cases ⁸	2,099,533	2,196,077	2,484,607	1,882,484	2,627,449
% Cases in children<5 ⁹	44%	46%	52%	39%	38%
Total # severe cases ¹⁰	70,048	75,555	106,927	103,946	80,321
Total # malaria deaths ¹¹	3,211	3,133	1,641	1,315	772
# Facilities reporting ¹²	2,273	2,415	2,623	2,710	2,743
% Data completeness ¹³	75%	76%	85%	100%	91%

1 Number of patients presenting with signs or symptoms possibly due to malaria (“suspect malaria cases” are defined as the presence 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 # <5 cases divided by total # of cases; 10 Severe Malaria Cases are reported in HMIS as a patient Tested positive with one or more signs of clinical or laboratory severity disturbances of consciousness including reactive coma (i- prostration; ii-Repeated seizures (> 2 episodes/24h) ;iii-Respiratory distress; iv- Hypoglycemia, Anemia ; 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 received 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	527,457	478,769	875,733
Total # of malaria cases reported by CHWs ¹	388,184	356,663	828,216
% of CHW reported cases (among total malaria cases) ²	8%	7%	26%

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 (%)
Abengourou/PermaNet 3.0	5.6.	0.0%	99.6%	N/A
Aboisso/Interceptor G2	5.6.	0.3%	98.4%	N/A

Table 7: Summary of Completed Therapeutic Efficacy Studies

Year	Site	Treatment arm(s)	Efficacy (PCR-corrected adequate clinical and parasitological result) for each drug at each site
2017	Abengourou, Abidjan, Korhogo, Man, San Pedro, Yamoussoukro	AL, ASAQ	Yes
2019	Abidjan, Bouna, Bouake, Daloa, Odienne, Aboisso, San Pedro, Man, Korhogo, Yamoussoukro, Abengourou, Adzope	AL, ASAQ	Yes

The 2021–2022 TES is the first one funded by PMI. Samples are currently being analyzed in-country. PMI looks forward to funding future studies in Côte d'Ivoire.

VI. KEY POLICIES

Table 8: Policies in Côte d'Ivoire

National Strategic Plan (April 2020)	
National Surveillance, Monitoring, and Evaluation Plan (2021)	
National Digital Health Strategy (under development)	
National Social Behavior Change/Communication Strategy (December 2021)	
National Supply Chain Strategy/Master Plan (December 2015)	
Vector Resistance Management Plan 2017- 2022	
Malaria Case Management Policy (2018)	
What is/are the first-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*?	Artesunate-Amodiaquine (AA) Artemether-Lumefantrine (AL) Dihydroartemisinin-Piperaquine (DP)

What is/are the second-line treatment(s) for uncomplicated <i>P. falciparum</i> malaria*?	Quinine
What is the first-line treatment for severe malaria?	Artesunate
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> ?	Quinine or Artesunate-Amodiaquine or AL orDP
In pregnancy, what is the first-line treatment for severe malaria?	Quinine injectable (IM) or Artesunate injectable (IV) or Artemeter injectable (IM)
Is pre-referral treatment of severe disease recommended at peripheral health facilities? If so, with what drug(s)?	Yes with Quinine
Is pre-referral treatment of severe disease with rectal artesunate recommended for community health workers?	Yes with Rectal Artesunate
Community Health Policy	
What is the # of CHWs currently providing iCCM?	11,397
What is the country's target for number of CHWs providing iCCM?	
What percent of the country's target is met?	
Does the country have a policy that enables the routine, regular payment of salaries/stipends for CHWs?	No
Do CHWs have the authority to test and treat all ages for malaria?	Yes
Prevention of Malaria in Pregnancy Policy	
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 maternal and child health?	Q2

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?	Yes
What is the status of training ANC providers on the WHO recommended 8+ contacts?	
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?	Yes
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">• Vector Control• Case management• Prevention• Procurement of national needs for SP• Training and supportive supervision	<ul style="list-style-type: none">• 68 of 113 health districts	\$23,000,000	Current grant covers 2021 to 2024