



## Summary update- GiveWell / Good Ventures funding for SMC

### Background

Malaria Consortium is currently implementing the last SMC season with UNITAID funding under the ACCESS-SMC project, with a focus on three countries, Burkina Faso, Nigeria and Chad. These three countries have had more difficulties transitioning to other funding sources (either domestic or international from sources such as the Global Fund, PMI or the World Bank). The three abovementioned countries make up, together with Mali and Niger, the bulk of the SMC eligible children in line with WHO guidelines, with Nigeria alone accounting for over 11M eligible children, of which only 1.7 are currently covered by ACCESS-SMC. In the whole Sahel region, over 12M children are still left out from SMC programs. The original ACCESS-SMC grant was expected to end on August 31<sup>st</sup>, but Malaria Consortium secured a cost extension up to February 28, 2018, to complete the third season in the abovementioned countries, and carry out an endline molecular markers' survey in the seven ACCESS-SMC countries<sup>1</sup>, to track trends in parasite resistance to SMC drugs.

UNITAID's support in 2017, however, left key funding gaps related to monitoring and evaluation costs, in particular coverage surveys and extra efforts/activities to improve monitoring in Chad and Nigeria, countries that show less positive results compared to other countries. These extra monitoring activities are intended to help perform a better analysis of the discrepancies around coverage surveys and administrative data, which in all countries have been significant.

SMC activities take place in yearly rounds (seasons) of four months during the peak of the rainy season, with four distribution / administration cycles within one round (roughly a cycle every 28 days / 1 month).

### GiveWell / Good Ventures funding allocations

Two dimensions of support were prioritized under the funding framework provided by Good Ventures through GiveWell recommendations on SMC:

- Operational support to SMC implementation, through expansion of Malaria Consortium involvement in areas previously covered by other donors but left unserved in 2017, or new areas not yet covered by any donors, and which would have not been supported otherwise. The extent of this new operational support was constrained by the timing of the funding confirmation with respect to the season [and capacity at the provider], which both affected the maximum amount of drugs that could be procured, produced, shipped and delivered in time for the 2017 season (approximately 1.6M blisters).
- Monitoring and evaluation support, specifically through the execution of multiple coverage surveys and enhanced in-process monitoring,

#### **a. Operational support**

Three countries have been prioritized for this support:

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<sup>1</sup> Burkina Faso, Chad, Guinea, Mali, Niger, Nigeria and the Gambia.

## Nigeria:

Since 2013, Nigeria was supported first by Bill & Melinda Gates Foundation and then through other one-off funding to implement SMC in six Local Government Areas (LGAs) in the States of Katsina and Jigawa. Through the funding provided by GiveWell / Good Ventures, Malaria Consortium reinstated support to these 6 LGAs that did not have any confirmed funding in 2017. In the meantime, Malaria Consortium has continued to support through ACCESS-SMC all the 37 LGAs in the two States of Zamfara and Sokoto. The combined effort aims to provide SMC to approximately 2M children.

By September 6, the country teams, in collaboration with MoH officials and CHWs, completed two full cycles out of the four, respecting the original SMC round schedule (end of July).

According to preliminary results, the overall administrative coverage (children reached vs. children targeted as per consolidated monitoring data) in Malaria Consortium's area of operation during cycle 1 was just under 98%, with a total of 2,023,649 children reached, against an estimated eligible target of 2,070,321 children. In areas that are 100% supported by GiveWell / Good Ventures funding (Katsina and Jigawa States, in red below), weighted average administrative coverage is just over 100%. Details are shown in the table in Annex 1 at the end of this update.

STATE	Target	Reach	Coverage
Sokoto	961,992	892,205	92.7%
Zamfara	847,838	870,537	102.7%
Katsina	188,194	196,274	104.3%
Jigawa	72,296	64,633	89.4%
<b>Total</b>	<b>2,070,321</b>	<b>2,023,649</b>	<b>97.7%</b>

Support by GiveWell / Good Ventures is provided in the form of drugs (approximately 1.2M of the dispersible SP+AQ blisters procured and being distributed in the GiveWell / Good Ventures target areas), logistics costs, operational support through training, incentives and formative supervision directed at community drug distributors (community health workers), as well as the health workers and officials who are meant to supervise them. Such funding also supports the standard monitoring framework (including distribution data collection and monitoring tools), as well as minimum dedicated MC staff for these non-ACCESS-SMC areas, and a proportion of key shared staff.

While overall administrative coverage seems positive, coverage surveys showed how significant improvements may be required in Sokoto State to enhance increased supervision, ensure better quality of administration and improve coverage in several LGAs within that State.

## Burkina Faso:

Burkina Faso is the third most populous country in terms of SMC eligibility behind Nigeria and Niger, with significant gaps in geographical coverage, but excellent performance where they managed to secure adequate funding. While large swathes of the country have managed to benefit from consistent funding for SMC, in other areas one-off funding has only provided intermittent coverage. Thanks to large amount of drugs left over from various partners' activities in 2016, Burkina Faso had drugs enough to cover approximately 360,000 extra children, but no operational costs to do so. Thus, Malaria Consortium through GiveWell / Good Ventures funding has started supporting three districts that had benefited from SMC in previous years, but which had no secured support for 2017, as well as five more new priority districts for SMC. The nature of this support is similar to the one in Nigeria, with the exception of drugs (already available): it includes logistics and operational support, training, incentives and formative supervision support to the required monitoring activities. Dedicated and shared staff are also part of this support framework. Besides what are now known informally as "GiveWell areas", Malaria Consortium

supports 31 more districts with ACCESS-SMC funding, two of which are being co-funded by UNICEF for operational costs.

By August 28, two full cycles had been successfully implemented in line with country's SMC round schedule. According to preliminary results, the overall administrative coverage in Malaria Consortium's area of operation was just over 100% during cycle 1 (1,749,883 children reached) and 99% during cycle 2 (1,721,129 children), against an estimated eligible target of over 1.7M children. In areas that are 100% supported by GiveWell / Good Ventures funding (the districts of Mangodara, Dafra, Lena, Kongoussi, Gourcy, Séguenega, Yako and Boussé), coverage was just over 101% for both cycle 1 and cycle 2. These districts are shown in red in Annex II.

The details are available in the tables in Annex II. These good results were confirmed by a coverage survey carried out after cycle 1, which showed that 94.5% of the households interviewed confirmed having received SMC. A survey for cycle 2 will be carried out during the second week of September.

#### Guinea Bissau:

This is a new country for Malaria Consortium, and the choice was linked to discussions held in February between the MoH / NMCP representative and Malaria Consortium ACCESS-SMC team in Ouagadougou during a joint Malaria Consortium / WHO / WAHO consultation meeting on SMC (13-15 February 2017). The original plan was to support two regions for a total of 80,000 children, and approximately 400,000 dispersible SP+AQ blisters were directed to Guinea Bissau. However, eventually the MoH managed to secure funding for half of this target (one region) through the UNDP, and as a consequence the support in Guinea Bissau will be limited to the region of Gabu in the East of the country, targeting approximately 40,000 children under 5. The drugs that will be left over from the current order will have expiration date beyond 2019, so they will be available for use for a new round in 2018.

The nature of this support is similar to that in Nigeria, including drugs procurement, logistics and operational support, training, incentives and formative supervision support to the required monitoring activities. Support is channeled through an Italian NGO (AIFO), which has operational presence at primary healthcare level in Gabu, with Malaria Consortium technical and programmatic support coming from both the ACCESS-SMC regional office in Kampala, the WACRO Office in Abuja, and the Burkina Faso Country Office (whose Country Director speaks fluent Portuguese).

Guinea Bissau uses a slightly different timeline for SMC, normally starting in mid-August due to a distinctive seasonality (closer to that found in The Gambia and in Senegal). The first cycle started on August 14<sup>th</sup>, and was completed by the end of the month. The length is justified because of a different approach, whereby fewer mobile teams of health workers join CHWs in their localities, to administer SMC and the move to the next areas, over the course of approximately three weeks. We are expecting to receive the coverage data for the first cycle after a review meeting on September 11. The second cycle is planned to start on September 14. Because of the size of the target, and the new presence in Guinea Bissau, Malaria Consortium decided to waive coverage surveys this year to focus on implementation. However, surveys would surely be added in case of additional support in 2018.

#### Chad:

Chad does not benefit strictly speaking from GiveWell / Good Ventures funding directed at specific areas. All the 14 districts, with an estimated target population of over 660,000 children, are supported mainly through ACCESS-SMC funding. During the first cycle, which started with some delays on August 16, and final data should be ready by the first half of September: from preliminary incomplete data from 12 out of 14 districts, it is expected that administrative coverage will be close to 95%.

Cycle 2 is expected to start on September 14.

## Summary

Overall, the comprehensive SMC implementation support in what we call internally “GiveWell Districts” will target approximately 650,000 children, at an approximate cost estimated at 2.5M USD for 2017 (with some carryover costs in 2018 for operational close-out, data analysis and reporting). Besides, the funding will support more generalized operational and M&E support as detailed below.

### ***b. M&E support***

Besides the full operational support in the countries above, gaps were identified in a number of M&E areas, due to a phasing out of support for established activities (such as coverage surveys) and/or because of quality assurance gaps identified during the 2015 and 2016 seasons. The following activities are thus supported through GiveWell / Good Ventures funding to complement ACCESS-SMC funding for SMC.

#### Coverage surveys:

After experiences in 2015 and 2016, when ACCESS-SMC carried out end-of-round surveys after the full four cycles in collaboration with LSHTM and local research firms or institutions, there was in certain countries (including Chad and Nigeria) uncertainty about the overall reliability of the results, as discrepancies between administrative data and surveys were quite considerable. As a consequence, Malaria Consortium planned for 2017 to carry out coverage surveys following each cycle, so that the results could be better used to triangulate coverage information with cycle-specific administrative and in-process monitoring data. GiveWell / Good Ventures funding will support four coverage surveys in Chad, Nigeria and Burkina Faso. Considering an estimated cost for each survey of approximately 40,000 USD, it is estimated that such surveys (carried out by independent firms or research institutions) will total roughly 480,000 USD in 2017. As mentioned above, part of this work is already ongoing, with one surveys carried out in Burkina Faso and one in Nigeria, and one currently ongoing Chad, all related to cycle 1. Cycle 2 coverage surveys in Burkina Faso and Nigeria are also imminent. As mentioned above, Guinea Bissau will not be included in these coverage surveys in 2017. All contracts with research institutions were signed in July.

To finalize the independent evaluation framework started under ACCESS-SMC, LSHTM will be also contracted in the role of independent technical advisory organization, supporting the revision of the evaluation protocols (whose amendments required a revised ethical approval), additional technical supervision of field surveyors, and the analysis and interpretation of results in collaboration with Malaria Consortium technical team. The role of LSHTM is expected to require roughly 300,000 USD over one year (July 2017 – June 2018, expected end date for the finalization of more nuanced analysis of coverage data). The contract with LSHTM was signed in early September due to legal discussions, but with validity from July, and the collaboration has been seamless also thanks to the funding from ACCESS-SMC.

The total support to coverage surveys (a total of 12) is thus estimated at just under 800,000 USD, but we expect that the actual costs may somehow lower..

#### Enhanced field monitoring activities and tools

A range of supportive initiatives to improve the SMC monitoring framework was identified and is being supported through GiveWell / Good Ventures funding in 2017 to improve delivery (or its tracking and quality assurance) in ACCESS-SMC areas. These include:

##### *i. Field data quality / monitoring staff:*

Seven temporary staff were recruited in Chad and, 43 (one per LGA) Nigeria, in order to improve supervision and monitoring and make sure that administrative data received is reflective of the real distribution process in the field. In addition, in Nigeria, independent monitors will carry out in-process monitoring during the cycles (while this role in Chad will be played by the temporary support staff mentioned above). Low coverage figures in Chad and Nigeria from coverage surveys cast doubts on the reliability of administrative data. By including hands-on supervisors / monitors to random-check distribution areas, the expectation is that we will be able to clear the air around potential misrepresentations of administrative coverage in the past two years.

Other efforts will be also supported in terms of improving supervision by local officials and health workers and other categories of supervisors (such as teachers in Nigeria to supervise CHW teams), through increased logistics support.

*ii. Enhance monitoring tools:*

New SMC child cards (which are normally distributed for multiple years) were printed in 2017, which included a unique identifier of 7 or 8 figures. These identifiers are reported into improved tally sheets, and collected at district/LGA levels in all target countries. The cost of reproducing these tools was not fully represented in the UNITAID budget, and not budget expansion was agreed. But as we consider these minor changes paramount for improved monitoring and child tracking, we decided to use some of the GiveWell / Good Ventures funding to support the reproduction of such tools. Currently, unique identifiers are being entered by data clerks in Burkina Faso and Chad.

The overall cost of this extra support is estimated at 400,000 USD. This is mostly focused on Nigeria and Chad, where the gaps are larger, and concerns on coverage and reach more significant.

Overhaul of Malaria Consortium SMC monitoring and data management framework:

Recognizing the limits of our previous data management and monitoring tools at central level, we decided to move to a more coherent SMC data management framework. In the last two years, with SMC being a new intervention at scale, Malaria Consortium has learnt by doing what are the basic tools and parameters to consider for adequate management of the massive amount of SMC data generated through a mass drug administration campaign to millions of children. While in the past two years all data were available, they were often spread across a number of formal and informal platforms, including country's HMIS, Malaria Consortium spreadsheets for SMC datasets, partners' data and an LSHTM repository.

In light of the renewed effort to better control and analyze SMC data, Malaria Consortium decided to contract Dharma for the establishment of a comprehensive platform for the storage, management and analyses of SMC data, including both administrative data and ad-hoc evaluation data such as those generated by coverage surveys. The estimated cost of this setup and platform management is approximately 100,000 USD for the current year (mostly related to setup, training and including 40,000 USD of license). Yearly license of 40,000 USD in subsequent years will need to be embedded in any future SMC proposal.

**ANNEX I – SUMMARY OF ADMINISTRATIVE COVERAGE DATA – NIGERIA – CYCLE 1**

No	SOKOTO STATE	Number of children who received SP+AQ						Grand Total	Target Population	% Coverage
		Male			Female					
	LGA	3-11 M	12-59 M	Total	3-11 M	12-59 M	Total			
1	Binji	2,711	8,073	10,784	3,617	8,724	12,341	23,125	27,329	84.6%
2	Bodinga	4,177	15,329	19,506	4,695	16,855	21,550	41,056	45,642	90.0%
3	Dange Shuni	4,290	16,046	20,336	4,662	17,476	22,138	42,474	50,623	83.9%
4	Gada	6,133	26,108	32,241	7,542	30,827	38,369	70,610	64,601	109.3%
5	Goronyo	3,952	14,647	18,599	4,013	14,735	18,748	37,347	47,435	78.7%
6	Gudu	2,128	9,216	11,344	2,440	10,207	12,647	23,991	24,862	96.5%
7	Gwadabawa	5,678	23,233	28,911	5,965	22,928	28,893	57,804	60,202	96.0%
8	Illela	3,453	13,452	16,905	3,764	13,057	16,821	33,726	39,159	86.1%
9	Isa	3,608	15,276	18,884	4,560	17,158	21,718	40,602	38,017	106.8%
10	Kebbe	3,179	9,765	12,944	3,529	10,005	13,534	26,478	32,437	81.6%
11	Kware	4,379	13,314	17,693	4,248	11,933	16,181	33,874	34,842	97.2%
12	Rabah	4,120	16,371	20,491	4,230	15,811	20,041	40,532	38,814	104.4%
13	Sabon Birni	4,403	14,584	18,987	5,718	17,017	22,735	41,722	54,019	77.2%
14	Shagari	4,391	14,170	18,561	4,395	14,008	18,403	36,964	40,700	90.8%
15	Silame	2,687	8,673	11,360	4,096	8,455	12,551	23,911	27,160	88.0%
16	Sokoto North	6,518	25,040	31,558	7,571	25,633	33,204	64,762	60,589	106.9%
17	Sokoto South	4,018	17,243	21,261	4,903	18,919	23,822	45,083	50,718	88.9%
18	Tambuwal	5,468	24,250	29,718	6,313	22,037	28,350	58,068	58,529	99.2%
19	Tangaza	3,291	10,942	14,233	3,983	12,488	16,471	30,704	29,626	103.6%
20	Tureta	1,293	5,555	6,848	1,460	5,735	7,195	14,043	17,790	78.9%
21	Wamakko	3,809	16,518	20,327	4,121	17,511	21,632	41,959	46,738	89.8%
22	Wurno	3,656	15,071	18,727	3,204	13,579	16,783	35,510	42,234	84.1%
23	Yabo	2,797	10,368	13,165	3,474	11,221	14,695	27,860	29,927	93.1%
<b>TOTAL VALIDATED</b>		<b>90,139</b>	<b>343,244</b>	<b>433,383</b>	<b>102,503</b>	<b>356,319</b>	<b>458,822</b>	<b>892,205</b>	<b>961,993</b>	<b>92.7%</b>

No	ZAMFARA STATE	Number of children who received SP+AQ						Grand Total	Target Population	% Coverage
		Male			Female					
	LGA	3-11 M	12-59 M	Total	3-11 M	12-59 M	Total			
1	Anka	3,631	14,513	18,144	4,843	17,785	22,628	40,772	37,023	110.1%
2	Bakura	3,300	14,011	17,311	3,779	14,607	18,386	35,697	48,634	73.4%
3	Brinin Magaji	3,184	14,083	17,267	4,431	16,928	21,359	38,626	46,478	83.1%
4	Bukkuyum	5,589	23,260	28,849	7,323	27,505	34,828	63,677	55,069	115.6%
5	Bungudu	7,258	28,688	35,946	8,940	31,962	40,902	76,848	67,112	114.5%
6	Gunmi	5,220	24,218	29,438	6,276	24,163	30,439	59,877	53,223	112.5%
7	Gusau	10,086	37,120	47,206	12,033	40,009	52,042	99,248	99,702	99.5%
8	Kara Namoda	6,055	22,013	28,068	7,551	24,308	31,859	59,927	73,214	81.9%
9	Maradun	5,256	23,335	28,591	6,443	25,794	32,237	60,828	54,866	110.9%
10	Maru	7,705	31,287	38,992	9,372	33,536	42,908	81,900	75,955	107.8%
11	Shinkafi	2,083	11,622	13,705	4,949	11,789	16,738	30,443	35,297	86.2%
12	Talata Mafara	5,399	24,291	29,690	6,382	28,782	35,164	64,854	55,991	115.8%
13	Tsafe	7,612	30,404	38,016	8,521	32,535	41,056	79,072	69,218	114.2%
14	Zurmi	6,832	29,291	36,123	8,390	34,255	42,645	78,768	76,055	103.6%
<b>VALIDATED TOTALS</b>		<b>79,210</b>	<b>328,136</b>	<b>407,346</b>	<b>99,233</b>	<b>363,958</b>	<b>463,191</b>	<b>870,537</b>	<b>847,838</b>	<b>102.7%</b>

No	KATSINA STATE*	Number of children who received SP+AQ						Grand Total	Target Population	% Coverage
		Male			Female					
	LGA	3-11 M	12-59 M	Total	3-11 M	12-59 M	Total			
1	Maiadua	4,273	14,592	18,865	4,774	16,513	21,287	40,152	50,623	79.3%
2	Dusti	4,300	15,884	20,184	5,829	19,931	25,760	45,944	45,642	100.7%
3	Mashi	6,627	26,260	32,887	8,981	30,700	39,681	72,568	64,599	112.3%
4	Baure	3,705	13,830	17,535	4,242	15,833	20,075	37,610	27,330	137.6%
<b>VALIDATED TOTALS</b>		<b>18,905</b>	<b>70,566</b>	<b>89,471</b>	<b>23,826</b>	<b>82,977</b>	<b>106,803</b>	<b>196,274</b>	<b>188,194</b>	<b>104.3%</b>

No	JIGAWA STATE*	Number of children who received SP+AQ						Grand Total	Target Population	% Coverage
		Male			Female					
	LGA	3-11 M	12-59 M	Total	3-11 M	12-59 M	Total			
1	Kazaure	4,668	13,589	18,257	6,295	15,993	22,288	40,545	47,435	85.5%
2	Roni	2,215	9,038	11,253	2,569	10,266	12,835	24,088	24,862	96.9%
<b>VALIDATED TOTALS</b>		<b>6,883</b>	<b>22,627</b>	<b>29,510</b>	<b>8,864</b>	<b>26,259</b>	<b>35,123</b>	<b>64,633</b>	<b>72,297</b>	<b>89.4%</b>

\* The direct operational costs for SMC in these two states are 100% funded by GiveWell / Good Ventures

**ANNEX II – SUMMARY OF ADMINISTRATIVE COVERAGE DATA – BURKINA FASO – CYCLE 1 & 2**

CYCLE 1						
N°	Districts	Number of children who received SMC			Target Population	% coverage
		3-11 M	12-59 M	Total		
<b>1</b>	<b>Mangodara</b>	<b>6,559</b>	<b>38,308</b>	<b>44,867</b>	<b>41,286</b>	<b>108.67%</b>
<b>2</b>	<b>Dafra</b>	<b>8,244</b>	<b>41,498</b>	<b>49,742</b>	<b>47,532</b>	<b>104.65%</b>
<b>3</b>	<b>Lena</b>	<b>1,892</b>	<b>11,454</b>	<b>13,346</b>	<b>13,574</b>	<b>98.32%</b>
4	Bittou	3,503	20,881	24,384	25,141	96.99%
5	Garango	5,647	30,088	35,735	36,265	98.54%
6	Koupéla	5,863	34,203	40,066	42,469	94.34%
7	Ouargaye	10,200	57,097	67,297	64,331	104.61%
8	Pouytenga	5,918	34,155	40,073	37,914	105.69%
9	Tenkodogo	5,579	35,772	41,351	41,838	98.84%
10	Zabré	4,318	24,809	29,127	28,782	101.20%
11	Barsalogo	5,712	34,142	39,854	38,737	102.88%
12	Boussouma	5,744	33,101	38,845	38,697	100.38%
13	Kaya	10,938	62,375	73,313	69,053	106.17%
<b>14</b>	<b>Kongoussi</b>	<b>10,378</b>	<b>54,997</b>	<b>65,375</b>	<b>67,685</b>	<b>96.59%</b>
15	Koudougou	8,663	49,160	57,823	64,402	89.78%
16	Léo	6,821	40,459	47,280	50,289	94.02%
17	Nanoro	4,291	25,311	29,602	31,223	94.81%
18	Réo	5,321	30,219	35,540	34,897	101.84%
19	Sabou	2,513	17,167	19,680	19,788	99.45%
20	Sapouy	6,608	38,017	44,625	44,017	101.38%
21	Tenado	4,986	28,600	33,586	32,730	102.62%
22	Kombissiri	4,644	27,359	32,003	33,971	94.21%
23	Manga	7,932	46,773	54,705	56,419	96.96%
24	Pô	5,030	31,732	36,762	36,835	99.80%
25	Saponé	2,678	15,066	17,744	18,084	98.12%
26	Bogandé	10,745	60,681	71,426	69,583	102.65%
27	Diapaga	13,062	73,463	86,525	91,332	94.74%
28	Fada	12,053	69,574	81,627	79,956	102.09%
29	Gayeri	3,410	19,775	23,185	21,951	105.62%
30	Manni	5,584	31,152	36,736	35,156	104.49%
31	Pama	3,444	21,046	24,490	22,530	108.70%
<b>32</b>	<b>Gourcy</b>	<b>5,388</b>	<b>34,299</b>	<b>39,687</b>	<b>40,791</b>	<b>97.29%</b>
<b>33</b>	<b>Séguenega</b>	<b>6,278</b>	<b>35,719</b>	<b>41,997</b>	<b>40,659</b>	<b>103.29%</b>
<b>34</b>	<b>Yako</b>	<b>11,317</b>	<b>65,783</b>	<b>77,100</b>	<b>75,987</b>	<b>101.46%</b>
<b>35</b>	<b>Boussé</b>	<b>4,675</b>	<b>27,683</b>	<b>32,358</b>	<b>31,812</b>	<b>101.72%</b>
36	Ziniaré	7,507	48,451	55,958	55,759	100.36%
37	Zorgho	11,124	68,671	79,795	75,457	105.75%
38	Boulsa	6,221	35,013	41,234	38,562	106.93%
39	Tougouri	6,744	38,296	45,040	42,320	106.43%
<b>Total</b>		<b>257,534</b>	<b>1,492,349</b>	<b>1,749,883</b>	<b>1,737,814</b>	<b>100.69%</b>



CYCLE 2						
N°	Districts	Number of children who received SMC			Target Population	% coverage
		3-11 M	12-59 M	Total		
1	<b>Mangodara</b>	<b>5,428</b>	<b>32,269</b>	<b>37,697</b>	<b>41,286</b>	91.31%
2	<b>Dafra</b>	<b>7,657</b>	<b>38,961</b>	<b>46,618</b>	<b>47,532</b>	98.08%
3	<b>Lena</b>	<b>1,909</b>	<b>11,898</b>	<b>13,807</b>	<b>13,574</b>	101.72%
4	Bittou	3,210	20,000	23,210	25,141	92.32%
5	Garango	5,404	29,780	35,184	36,265	97.02%
6	Koupéla	5,778	34,384	40,162	42,469	94.57%
7	Ouargaye	9,001	55,612	64,613	64,331	100.44%
8	Pouytenga	n/a	n/a	n/a	37,914	n/a
9	Tenkodogo	6,605	35,545	42,150	41,838	100.75%
10	Zabré	4,430	25,320	29,750	28,782	103.36%
11	Barsalogo	5,855	34,056	39,911	38,737	103.03%
12	Boussouma	5,602	33,306	38,908	38,697	100.55%
13	Kaya	10,903	62,935	73,838	69,053	106.93%
14	<b>Kongoussi</b>	<b>10,283</b>	<b>57,875</b>	<b>68,158</b>	<b>67,685</b>	100.70%
15	Koudougou	8,708	51,632	60,340	64,402	93.69%
16	Léo	7,547	40,271	47,818	50,289	95.09%
17	Nanoro	4,291	25,284	29,575	31,223	94.72%
18	Réo	5,503	30,509	36,012	34,897	103.20%
19	Sabou	2,638	17,365	20,003	19,788	101.09%
20	Sapouy	6,299	38,499	44,798	44,017	101.77%
21	Tenado	5,039	29,213	34,252	32,730	104.65%
22	Kombissiri	4,645	28,342	32,987	33,971	97.10%
23	Manga	7,431	44,483	51,914	56,419	92.02%
24	Pô	5,016	32,880	37,896	36,835	102.88%
25	Saponé	2,855	15,292	18,147	18,084	100.35%
26	Bogandé	10,925	61,699	72,624	69,583	104.37%
27	Diapaga	13,916	79,962	93,878	91,332	102.79%
28	Fada	11,842	70,527	82,369	79,956	103.02%
29	Gayeri	3,431	19,734	23,165	21,951	105.53%
30	Manni	5,411	32,068	37,479	35,156	106.61%
31	Pama	3,527	21,066	24,593	22,530	109.16%
32	<b>Gourcy</b>	<b>5,465</b>	<b>35,947</b>	<b>41,412</b>	<b>40,791</b>	101.52%
33	<b>Séguenega</b>	<b>6,411</b>	<b>36,259</b>	<b>42,670</b>	<b>40,659</b>	104.95%
34	<b>Yako</b>	<b>11,513</b>	<b>68,747</b>	<b>80,260</b>	<b>75,987</b>	105.62%
35	<b>Boussé</b>	<b>4,824</b>	<b>27,974</b>	<b>32,798</b>	<b>31,812</b>	103.10%
36	Ziniaré	7,628	48,660	56,288	55,759	100.95%
37	Zorgho	11,086	68,144	79,230	75,457	105.00%
38	Boulsa	6,137	35,214	41,351	38,562	107.23%
39	Tougouri	6,698	38,566	45,264	42,320	106.96%
Total		257,534	250,851	1,470,278	1,721,129	99.04%