Joint Appraisal report (JA) 2018

BURKINA FASO

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes ■	No ☐	NA ☐
HSS renewal request	Yes ■	No ☐	NA ☐
CCEOP renewal request	Yes ☐	No ☐	NA ■

Observations on vaccine request

Total population	19,632,147				
Birth cohort	867,778				
Vaccine	MenA	Penta	PCV-13	Rota	MR
Population in the target age cohort	747,632	762,074	762,074	762,074	762,074
Target population to be vaccinated (first dose)	523,342	762,074	762,074	762,074	762,074
Target population to be vaccinated (last dose)	NA	762,074	762074	762074	762074
Implied coverage rate	70%	100%	100%	100%	100%
Last available WUENIC coverage rate	NA	91%	91%	91%	88%
Last available admin coverage rate	68%	106%	106%	101%	101%
Wastage rate	25%	5%	5%	5%	25%
Buffer	178,000	601,900	200,700	200,700	169,500
Stock reported	271,000	399,950	255,000	633,725	1,201,770

The time frame for submitting NVS renewal requests is satisfactory. We triangulated between the Forecast numbers and the Gavi portal numbers. The needs estimate includes all factors (2018 target population, goal (100%), number of contacts per antigen and wastage factor).

The country plans a yearly buffer stock of three months, or 25% of annual needs. The yellow fever (YF) vaccine experienced a 118-day stockout in 2017 due to worldwide vaccine shortages and a delay in transferring funds to purchase inputs. No vaccine wastage was reported. A gap between the quantity of rota vaccine planned (2,304,000) and the amount received (2,170,150) as funded by Gavi was noted.

Burkina Faso wishes to increase the MenAfriVac™ vaccine wastage rate to 50% to boost immunisation coverage but would like Gavi to support payment for this.

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[1]

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future	Schedule	Expected application year	Expected introduction year
	HPV vaccine	2019	2022
	Additional HSS3	2018	2019

2. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

The security situation is deteriorating in the North, Sahel and East regions, causing uncontrolled movement of people and some health facilities to close. There is a risk that the situation of unimmunised or under-immunised children could lead to epidemics. Additionally, refugees from Mali have settled in the Sahel. Population growth in peri-urban areas also creates a risk of inadequate immunisation.

Repeated staff changes have caused delays in funding and implementing some of the programme's activities.

The transition plan is currently being written. Gavi/HSS3 funding should be allocated to implement activities related to this transition – specifically for monitoring and communication.

Five most important risks:

- Lack of qualified staff at all levels may be the root cause of management difficulties and the programme's under-performance.
- Aging and poorly maintained health facility vehicles could prevent implementation of the outreach strategy and lead to an increased number of unimmunised children.
- The worsening condition of cold chain equipment can create vaccine storage problems.
- The continued degradation of the security situation in Burkina Faso may lead to further displacement of populations, who are then difficult to reach with current immunisation strategies. This might also cause technical and financial partners (TFPs) to withdraw, leading to a potential lack of funding.
- Documented deficiencies in immunisation and surveillance data quality have made it difficult to assess the programme's actual performance. This might reduce access to certain types of funding.

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

3.1. Coverage and equity of immunisation

Performance

From 2015 to 2017, administrative immunisation coverage varied from 100% to 105%. Only YF, Measles/Rubella2 (MR2) and MenA recorded coverage of less than 90%.

For YF specifically, immunisation coverage fell from 100% in 2015 to 57% in 2016 and 46% in 2017, due to worldwide stockouts of the antigen.

MR2 was introduced in 2015 and immunisation coverage has risen steadily, from 65% in 2015 to 75% in 2016 and 80% in 2017.

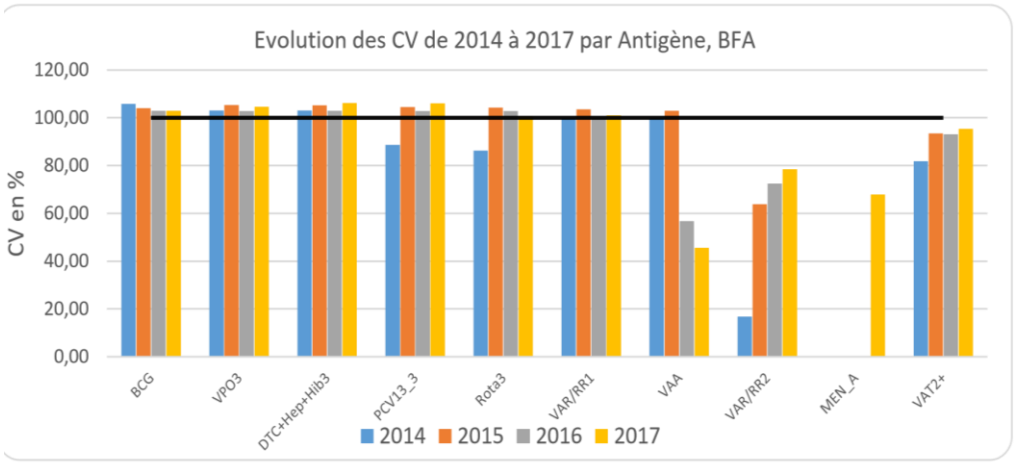
MenA was introduced in March 2017 and coverage was 68% against a target of 70%. WHO/UNICEF estimates for 2017 showed immunisation coverage of 95% for BCG, Penta1, Pneumo1 and TT2+; 91% for Penta3, Pneumo3 and Rota3; 88% for MR1; 50% for MR2; and 49% for YF. These estimates confirm the same trends, but there is a gap of more than 10 points compared to administrative data, which translates into data quality problems.

[1] *If taking too much space, the list of participants may also be provided as an annex.*

Change in immunisation coverage from 2014 to 2017 by antigen, BFA

Vertical axis: Immunisation coverage in %

Horizonal axis: BCG, OPV3, DTP+Hep+Hib3, PCV-13-3, Rota3, MCV/MR1, YF, MCV/MR2, MenA, TT2+



Source : Rapports de routine PEV/DPV

Graphique n°1: Evolution de la couverture vaccinale de tous les antigènes de 2014 à 2017

Source: Routine EPI/DPI reports

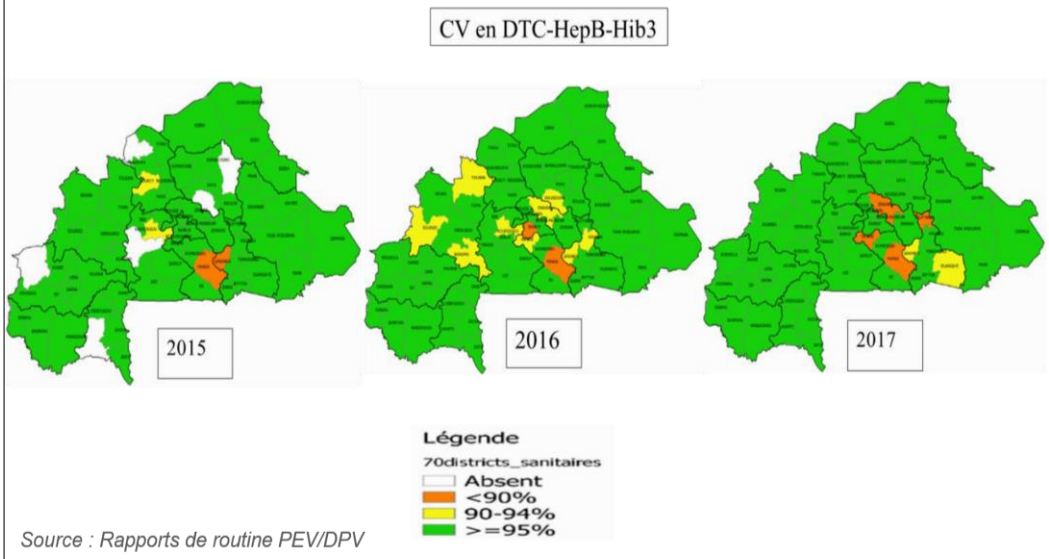
Figure 1: Changes in immunisation coverage for all antigens, 2014-2017

Status of districts with low DTP-HepB-Hib3 coverage

Use of maps/hotspot maps to show data - DTP-HepB-Hib3 immunisation coverage

Situations des districts à faible niveau de couverture par DTC+ HepB-Hib3

Éventuellement, utilisation de cartes/cartes des points chauds pour présenter les données.



Source : Rapports de routine PEV/DPV

Figure n°3 : Situation des districts sanitaires à faible performance pour le DTC-Hep-Hib3 de 2015 à 2017

Entre 2015 à 2017 le nombre de districts à faible performance en Penta3 (< 90%) est passé de deux (DS Manga et DS Garango) à quatre (Manga, Saponé, Pouytenga et Ziniaré).

Legends: 70 health districts

Source: Routine EPI/DPI reports

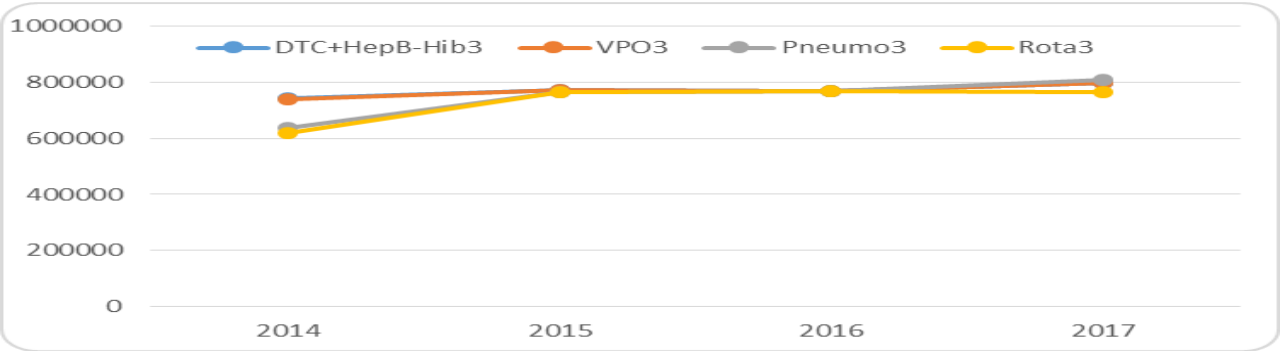
Figure no. 3: Status of districts with low DTP-HepB-Hib3 coverage from 2015 to 2017

Between 2015 and 2017, the number of districts with low Penta3 performance (<90%) increased from two (Manga and Garango) to four (Manga, Saponé, Pouytenga and Ziniaré).

Infants not immunised or not sufficiently immunised with DTP1 and DTP3

More than 7,000 children who were not immunised with Penta3 were documented in two health regions (Centre East, 5,512 or 8% of the target; and Centre South, 1,970 or 6% of the target) according to the expected targets.

Missed opportunities for immunisation: Potential missed opportunities as compared with antigens administered at the same time (eg MCV1 and YF, or Penta3, OPV3 and PCV3).



Source:: Administrative data / DPV

Figure No. 7 : Comparison of number of children receiving DTP+HepB-Hib3, OPV3, Pneumo3 and Rota3 from to 2017 at the same time

A survey on missed opportunities for immunisation conducted in eight health districts and seven health regions in 2016 (AMP) showed that the prevalence of missed immunisation opportunities was 60%.

Equity

Immunisation is free in Burkina Faso

Between 2014 and 2017, there was a significant increase in the number of health centres offering immunisation activities. There were 2,017 health facilities in 2017, up from 1,798 in 2014, a development that improved public access to health services.

According to the 2015 Continuous Multisectoral Survey (CMS), the proportion of children aged 12-23 months who received all of their vaccines varied by area of residence: it was 83% in rural areas versus 89% in urban areas). Discrepancies between regions were significant, with immunisation coverage of 96% in the South West versus 57% in the Sahel. Children's immunisation coverage levels increased with household socio-economic levels, from 78% in children from households in the “very poor” quintile to 88% in those from “very wealthy” households. Coverage also increased with the mother's education level: only 82% of children whose mothers had no education were fully immunised versus 91% whose mothers had a primary school education and 93% whose mothers had a secondary school education or hi9gher.

An immunisation equity analysis in three districts (Manga, Garango and Koudougou) in 2017 documented the current situation and showed significant deficiencies, namely:

- inadequate community dialogue;
- inadequate responsiveness from the health system (intake, high-quality services, interpersonal communication, professional confidentiality, etc);
- home births;
- lack of personnel and poor geographic accessibility of services (rivers, nomadic populations, migration, gold panning, etc) and a lack of vehicles;

- poor governance of health facilities, which has a particularly negative effect on immunisation. The state does not conduct even a minimal level of management duties and activities (supervision, staff, holding cooperation meetings, briefing teams, etc);
- lack of outreach strategy missions;
- poor functionality of MCs due to lack of training and low levels of involvement in health district activities; and
- workers not regularly trained in immunisation.

Surveillance of vaccine-preventable diseases (VPDs) and AEFIs

Number of cases (suspected and confirmed): Measles, rubella, CRS, AFP, YF, MNT, rotavirus diarrhoea

Table I: Performance indicators of AFP surveillance from 2015 to 2017

INDICATORS	Norm	2015	2016	2017	June 2018
Polio					
Rate of non-poliomyelitis AFP for 100,000 children aged less than 15 years	>=2	3.21	2.97	3.33	3.46
Percentage of AFP cases for which samples were collected within the required 14 days of when paralysis began	>=80%	91%	92%	90%	94%
Percentage of health regions that achieved the two major AFP surveillance indicators	>=80%	97%	100%	92%	85%

Source: Ministry of Health (MoH) administrative data

Performance of the two major indicators has been good since 2015. In 2017, only one region (Central Plateau) failed to achieve the two major AFP surveillance indicators. This performance decreased in 2017 and 2018.

Table II: Measles surveillance indicators from 2015 to 2017

INDICATORS	Norm	2014	2015	2016	2017
MEASLES					
% of health districts reporting and sampling at least one case	≥ 80%	90%	76%	66%	74%
% of cases sampled	80%	34%	87%	91%	96%
% of cases confirmed	< 10%	43%	38%	50%	20%
% of non-measles febrile rash	≥ 2 per 100,000	2.55	0.73	0.99	0.62

Source: Ministry of Health (MoH) administrative data

In 2017, 26% of districts did not report suspected measles cases.

Epidemics

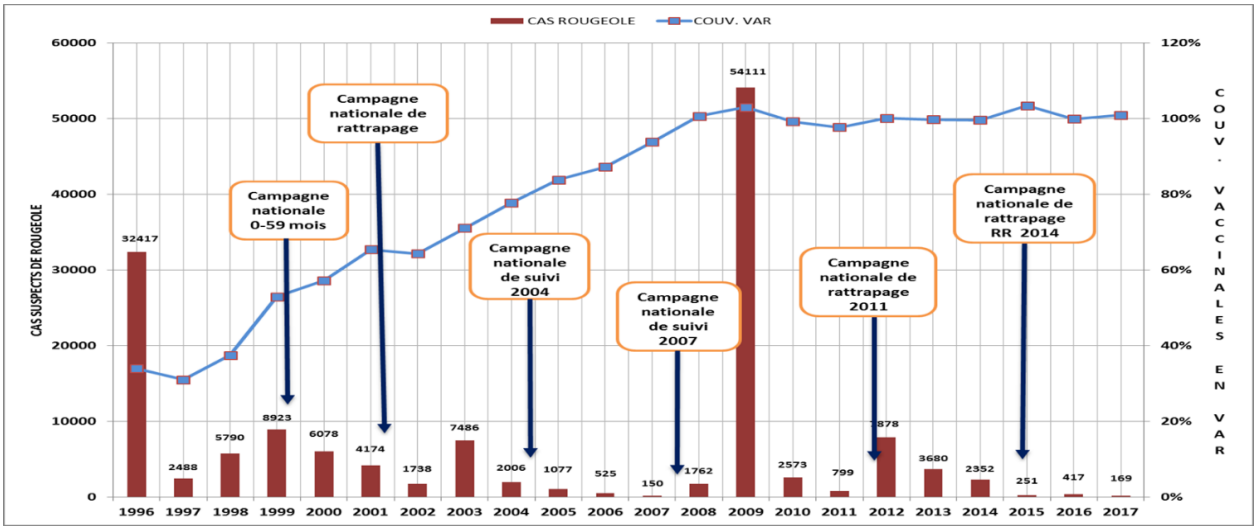


Figure no. 8: Change in immunisation coverage and measles cases, and interventions conducted between 1996 and 2017

Legend: Red= Measles cases; Blue line with bars= MCV coverage
Vertical axis: Suspected measles cases

Text bubbles, left to right: National campaign, 0-59 months; National catch-up campaign; National monitoring campaign 2004; National monitoring campaign 2007; National catch-up campaign 2011; National MR catch-up campaign 2014

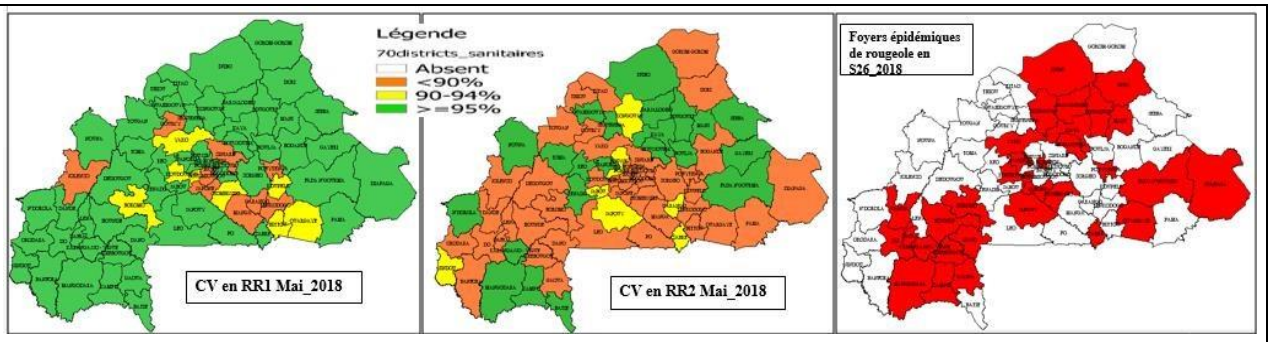
Measles prevention benefited from catch-up campaigns in 2001, 2011 and 2014, a response campaign in 2009 and monitoring campaigns in 2004, 2007 and 2011. Specifically, in 2012, a preventive campaign targeting Malien refugees was organised in the Sahel, Centre, Boucle du Mouhoun and East regions.

Table II: Distribution of confirmed measles cases by age and vaccine status from 2015 to 2017

Age group	Zero dose		1 dose		2 doses plus		Total with immunisation status
	(n)	(%)	(n)	(%)	(n)	(%)	
0-8 months	24	96%	1	4%	0	0%	25
9-11 months	9	100%	0	0%	0	0%	9
1-4 years	74	89%	9	11%	0	0%	83
5 -14 years	70	86%	10	12%	1	1%	81
15+ years	104	95%	5	5%	1	1%	110
Total	**281**	**91%**	**25**	**8%**	**2**	**1%**	**308**

Source: Ministry of Health (MoH) administrative data

Comments: Between 2015 and 2017, 308 confirmed cases of measles were reported of which 91% had not been immunised.



. Legend= 70 health districts

Title on right-hand graph= Epidemic measles flareups in week 26 of 2018
Title on left-hand graph: MR1 measles immunisation coverage, May 2018
Title on centre graph: MR2 measles immunisation coverage, May 2018
Source: Ministry of Health (MoH) administrative data

Comments*:*

A cross-analysis of monitoring performance against coverage for the past three years for the measles/rubella (MR) vaccine, and the cumulative incidence of cases by district in the total population shows:

- districts with epidemics with a high level of incidence in 2015, 2016, 2017 and 2018;
- a majority of districts with low MR2 immunisation coverage (<90%);
- contrast with certain districts with satisfactory MR1 immunisation coverage.

In the first 22 weeks of 2018:

- 3,597 suspected measles cases were reported of which 1,750 were sampled and 812 confirmed;
- a marked increase in the incidence of disease and epidemics similar to that in 2009 when there were 59,111 measles cases; and
- 82 confirmed cases or 10% had received a dose of MR;

The recurrence of epidemics despite good coverage in certain districts (Banfora, Barsalgho, Djibo, Dori, Fada, Gaoua, Kampti, Kongoussi, Mangodara, Manni, Pouytenga and Sapouy) shows the need for a study to evaluate vaccine quality, data quality, and vaccine effectiveness.

Epidemic flareups were seen in 3 districts in 2016, 11 districts in 2016 and 5 districts in 2017.
The Sahel region had measles epidemic flareups from 2015 to 2017. Five health districts (Djibo; Dori, Kampti, Kongoussi and Sapouy) in four regions (Sahel, South West, Centre North and Centre West) had epidemic flareups in 2017.

Nombre de MAPI signalées

Tableau IV: Répartition des cas de MAPI notifiés de 2015 à 2017

Indicateurs	Période		
	2015	2016	2017
Nombre total de cas de MAPI mineures notifiés	16 192	15 801	15 218
Nombre de cas de MAPI graves notifiés	7	1	2
Nombre de cas de MAPI graves signalés et ayant fait l'objet d'une enquête	7	1	2
Ratio de notification des MAPI pour 100 000 nourrissons survivants par an	2 211	2 114	1 997

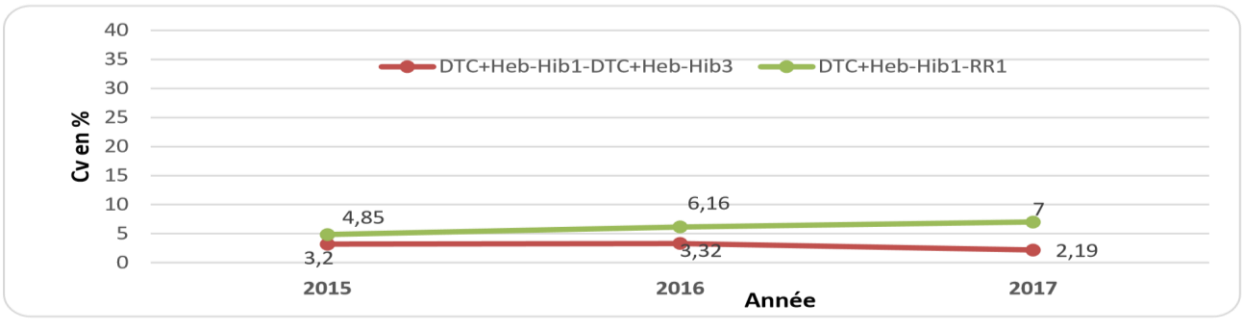
Source : Système de surveillance/ DPV

Legend: **Number of reported AEFIs**
Table IV: Breakdown of AEFI cases reported from 2015 to 2017
Column A: Indicators; Total number of minor AEFI cases reported; Number of serious AEFI cases reported; Number of serious AEFI cases reported and surveyed; Ratio of AEFI notifications per 100,000 surviving infants per year

Source: Surveillance systems/DPI

Demande

Taux d'abandon (DTC-Heb-Hib1/ DTC-Hep-Hib3 et DTC-Heb-Hib1/RR1)



Source : Données administratives

Graphique n°9 : Évolution des taux d'abandon DTC-Heb-Hib1/ DTC-Hep-Hib3 et DTC-Heb-Hib1/RR1 de 2015 à 2017

Commentaire : On a noté une augmentation du taux d'abandon DTC-HepB-Hib1/RR1 au fil des ans traduisant un nombre de plus en plus important d'enfants non vaccinés contre la rougeole et la rubéole. Ce qui pourrait expliquer la survenue des épidémies récurrentes.

Demand

Dropout rate (DTP-HepB-Hib1/DTP-HepB-Hib3 and DTP-HepB-Hib1/MR1)

Vertical axis: Immunisation coverage in %

Horizontal axis: Year

Red= DTP+HepB+Hib1+DTP+HepB+Hib3

Green: DTP+HepB+Hib1+MR1

Source: Administrative data

Graph no. 9: Change in dropout rates for DTP-HepB-Hib1/DTP-HepB-Hib3 and DTP-HepB-Hib1/MR1 from 2015 to 2017

Comments: We see an increase in the dropout rate for DTP-HepB-Hib1/MR1 over the years, translating into a growing number of children not immunised against measles and rubella. This might explain the recurring epidemics.

3.2. Key drivers of sustainable coverage and equity

Healthcare work force

- Lack of staff in some health centres (9% of health centres did not have the standard minimum number of staff in 2017).
- Staff at all levels are inadequately trained in EPI management.
- Staff are concentrated in urban areas to the detriment of rural areas.
- Health facility and health district managers have poor management capabilities.
- There is a lack of supervision of implementation of EPI activities.
- The work structure is not motivating.
- There is a lack of health facility management training for district management teams and chief post nurses (EPI).
- There is inadequate communication between health staff and the public in terms of advice about immunisation.
- There is poor functionality of MCs due to a lack of training and their low level of involvement in health district activities.

Supply chain

- A plan to build a new central warehouse is in progress, with a site identified.
- CCEOP: an operational deployment plan for equipment has been sent to UNICEF (605 pieces of cold chain equipment expected in 2018).

- 70 refrigerators were purchased for the country's 70 districts.
- Health centres were provided with 385 motorbikes for outreach strategies.
- MULTiLOG2s were installed in 13 regional warehouses for monitoring cold room temperatures.
- There were delays in transferring funds allocated to purchasing immunisation inputs, causing stockouts.
- There was a worldwide stockout of YF vaccine.
- 728 out of 2,017 health centres that provide immunisation have motorbikes for the outreach strategy; 288 out of 2,228 health centres do not have an adequate and operational cold chain.
- Cold chain equipment is old and outdated (with frequent breakdowns, lack of available parts, etc).
- There is a lack of voltage regulators for equipment at the central, regional and district level.
- Financial resources are allocated to resupply regions, districts and health facilities with vaccines and consumables.
- Five cold rooms have only one refrigeration unit; if that unit stops working, it will cause a breakdown. Three cold rooms at the central level are not connected to a backup generator; they stop working if there is a power outage.
- In four cold rooms at the central level, one of the two refrigeration units is not working.
- The central warehouse has only one refrigerated truck, which is inadequate for resupplying the regions.
- Cold rooms are subject to frequent power outages and to problems with the generators.
- There are deficiencies in destroying immunisation waste.
- The most recent EVM was in 2012. A new EVM is urgently needed and one is planned for 2018. There is still a gap of approximately US$ 40,000 for this evaluation.
- Mothers do not know the immunisation schedule.
- Lack of micro-planning for EPI communication activities.
- Inadequate monitoring of communication activities.
- Insufficient documentation on the reasons for not immunising.
- Lack of collaboration between actors (health personnel, associations, NGOs, etc) that work to implement the programme's activities.
- Ongoing issue with unimmunised children due to lower coverage in specific zones (poor areas, markets, etc).
- Lack of organisation of immunisation services and active search for dropouts.
- Health facilities' lack of promotion and outreach due to an absence of EPI educational media (megaphones, image boxes, guide pamphlets, etc).
- Lack of communication skills to promote the EPI, which influences programme performance.
- Insufficient participation by all actors in immunisation activities (municipalities, communities, civil society, etc).

Barriers linked to gender inequality encountered by caregivers

- Failure to take into account women's activities when immunisation sessions are scheduled.
- Women have little autonomy in decision-making.
- Men are not involved enough in immunisation.

Leadership, management and coordination

- High-level political commitment to immunisation (a budget line item is dedicated to purchasing traditional vaccines and to co-financing of new vaccines). The Burkina Faso president was named "immunisation champion of 2018" by Gavi.
- The Interagency Coordinating Committee (ICC) is functional and holds regular meetings (in 2017 six meetings were held; two were extraordinary meetings).
- The EPI Technical Advisory Group (TAG) is operational but the quality of the documents submitted to the ICC must improve.
- The National Immunisation Technical Advisory Group (NITAG) had operational difficulties in 2017 related to funding problems.
- Management committee meets regularly (2016: 12/12 and 2017: 12/12).

Cooperation frameworks at the regional and district level exist but immunisation-related analyses are insufficient.

3.3 Data

The review of data from the past three years revealed problems with data quality that remain unresolved. These include:

- problems related to estimating the size of the target population;
- immuunisation coverage greater than 100% in 70% of districts (49/70 in 2017);
- negative dropout rates in 36% of districts (25/70 in 2017); and
- inconsistencies between immunisation coverage and surveillance data; inconsistent coverage of antigens administered at the same time; and poor availability of DQS and survey data.

The analysis of data from 2017 revealed several limitations in the various components of data quality, as shown in the table below.

Table II: Findings from the 2017 immunisation data analysis

Data quality component	2017 results
1. Completeness of reports sent	National level of district report completeness = 100%
2. On-time rate of reports sent	National level of district report on-time rate = 99% National level of regional report on-time rate = 100%
3. Internal consistency of reported data	
Extreme outlier values	No district had extreme outlier values for the three vaccines (OPV3, DTP-HepB-Hib3, YFV) compared to the averages for the three previous years
Data consistency from one year to the next	13 districts (9%) with diverging scores for OPV3 and DTP-HepB-Hib3 47 districts (67%) had diverging scores for YFV
Consistency between related indicators	OPV3 / DTP-HepB-Hib3 comparison: 22 districts (31%) had diverging scores DTP-HepB-Hib3 / DTP-HepB-Hib1 comparison: 25 districts (36%) with diverging scores
4. External consistency of reported data	Comparison of routine data (OPV3 and Penta3) 2017 with 2010 population survey values: 7 districts (54%) had diverging scores

- The DHIS2 was implemented and has been operational in the districts since 2017 and includes EPI data. However, there are tremendous difficulties with internet access, making it difficult to enter health data.
- The country has created a strategic plan 2018-2022 to improve data quality and a 2018 operational data quality plan; however, there are no resources to implement these.
- A document review of 2017 immunisation data has been done and a report is available.
- Revision of the immunisation guide containing data management was undertaken.
- Training of EPI managers on immunisation data quality (DRS) took place.
- Discrepancies exist between data from different sources (administrative, WHO/UNICEF estimates and surveys) with discrepancies <10.
- There is inadequate availability of updated immunisation tools for the districts.
- There was preparation and distribution of EPI information and feedback bulletins by the central level in the form of monthly feedback on data use.
- There are insufficient resources to regularly organise periodic data validation meetings by level, and decentralised meetings.

- Specific supervision (data quality supervision) and immunisation monitoring activities are left up to the facilities because these activities are decreasingly supported by funding (research, surveys, DQS and LQAS have not been done for several years).
- Trained staff are continually on the move due to reassignments, promotions through competitive exams, temporary assignments and availability.

3.4. Immunisation funding

- There is a health funding framework. The Ministry of Health organises sessions every year to fund action plans for all health facilities. These sessions are held following preparation of the plans according to the planning directives.
- The annual budget has a line item for vaccine purchases. In 2017, the amount earmarked for vaccine purchases was US$ 3,090,909, compared to US$ 2,181,818 in 2016, representing a 41.66% increase. Even with this additional boost, resources remain insufficient in light of the support activities that need funding. These include implementing outreach immunisation activities in health facilities despite the involvement of technical and financial partners. Disbursements occur quarterly and can be late, causing stockouts.
- Burkina Faso subscribes to the Vaccine Independence Initiative. Implementing this initiative would resolve vaccine supply delays caused by the central government's late payments for vaccine co-financing. This process is being finalised.
- In the context of the budget framework approved by Burkina Faso, negotiations should allow for better channelling of financial resources to implement immunisation support activities.
- Activity execution structures and programmes submit their annual action plans, which are funded through implementation agreements signed for this purpose. After such agreements are signed, the funds are sent by wire transfer or by check, depending on the facility.
- In the context of managing funds received from partners, periodic financial reports are prepared and submitted in a timely manner. To date, the country has always complied with reporting deadlines.

4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

- Following the November 2016 catch-up campaign, MenA was introduced in March 2017 and the country recorded coverage of 68% against a target of 70%. Difficulties related to MenA immunisation could be caused by – among other factors – problems with getting mothers to comply with the new immunisation schedule and missed opportunities due to concerns with minimising wastage.
- Burkina Faso wishes to raise the MenAfriVac wastage rage to 50% with the goal of increasing immunisation coverage but would like Gavi to support payment for this.
- In 2017, Gavi support for Burkina Faso for co-financing the purchase of vaccine inputs concerned vaccines (DTP-HepB-Hib, Rota, MR, PCV-13, MenA), auto-disable syringes (AD 0.5 ml), 0.5 ml dilution syringes and 5 ml sharps boxes. The country also conducted a demonstration of the HPV vaccine between 2015 and 2017 and plans to introduce the IPV in 2018. A measles monitoring campaign is planned for 2019.

Transition from the monodose vial for PCV-13 to the multidose vial (four-dose vial) is also planned for 2018.

Overall progress of implementation of Gavi vaccine support

In general, Gavi vaccine support made it possible to maintain progress by conducting regular immunisations and introducing new vaccines into the routine immunisation programme. However, introduction of IPV scheduled for 2015 was delayed because of a worldwide vaccine shortage.

- No immunisation campaigns were organised in 2017.
- The measles situation analysis is attached to the report.
- In 2019, Burkina Faso will apply for introduction of the HPV vaccine and will organise a measles and rubella monitoring campaign.

4.2. Performance of Gavi HSS support (if country is receiving Gavi HSS support)

Objective 1: Strengthen coordination, monitoring, and evaluation of the health system from 2018 to 2022	
Objective of the HSS grant (as per the HSS proposals or PSR)	
Priority geographies/population groups or constraints to C&E addressed by the objective	
% activities conducted/budget utilisation	**100%**
Major activities implemented and review of implementation progress, including key successes and outcomes/activities not implemented or delayed/financial absorption	Finalise health system strengthening plan Complete a review of the HSS2 Support UG-NITAG operations Purchase 60 additional motorbikes for immunisation outreach strategies in the health facilities. Support DPI activities Purchase 13 complete desktop computers (computer + printer + surge protector) to install multilogs in the 13 regions
Major activities planned for upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance)	HSS2 is closed
Objective 2: Improve immunisation services by increasing – from 55.5% to 90% – the percentage of districts with 100% of children fully immunised by the end of 2022	
Objective of the HSS grant (as per HSS proposals or PSR)	
Priority geographies/population groups or constraints to C&E addressed by the objective	
% activities conducted/budget utilisation	**86%**
Major activities implemented and review of implementation progress, including key successes and outcomes/activities not implemented or delayed/financial absorption	Ensure that investigations are completed for AFP cases Ensure that 2,500 immunisation schedule posters are printed Purchase 12 Lenovo ThinkPad laptop computers for the DPI

	Train/retrain two workers per CSPS in EPI management: 70 five-day sessions in the health districts.
	Workers responsible for EPI management should perform supervision visits to all health regions
	Resupply the DRS with vaccines and consumables
	Train district and region EPI coordinators to use Endos; three sessions, five days each.
Major activities planned for upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance)	
Objective 3: Increase the routine immunisation data concordance index from 93.6% to 97% by the end of 2022	
Objective of HSS support (as per HSS proposals or PSR)	
Priority geographies/population groups or constraints to C&E addressed by the objective	
% activities conducted/budget utilisation	**100%**
Major activities implemented and review of implementation progress, including key successes and outcomes/activities not implemented or delayed/financial absorption	Purchase replacement parts (five refrigeration sets for the positive cold rooms, one inverter box for the generator with AMF, one box for the cold room)
	Maintain cold rooms and DPI resupply vehicles
	Produce and broadcast a media spot on routine immunisation
Major activities planned for upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance[2])	
Objective 4: Strengthen the supply chain for vaccines, consumables and logistics at all levels	
Objective of HSS support (as per HSS proposals or PSR)	
Priority geographies/population groups or constraints to C&E addressed by the objective	
% activities conducted/budget utilisation	**100%**
Major activities implemented and review of implementation progress, including key successes and outcomes/activities not implemented or delayed/financial absorption	Make copies of EPI management tools

[2] Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should, however, describe – to the extent known to date – the type of TA required (staff, consultants, training, etc), the provider of TA (core/expanded partner), the quantity/duration required, modality (embedded, sub-national, coaching, etc), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

- *Achievements against agreed targets, as specified in the grant performance framework (GPF), and other grant-related activity plans. Ex: comparing the number of additional children immunised, and the number of under-immunised children in districts receiving HSS support, versus districts not receiving support. What GPF indicators have been affected by the activities implemented*

Number of additional children immunised (from one year to the next)

Year	Penta3			
	Target	Immunised	Addl	%
2014	719,287	741,553	22,266	3%
2015	732,675	771,304	38,629	5%
2016	747,362	769,490	22,128	3%
2017	762,074	808,698	46,624	6%

From 2014 to 2017, an average of 3% more children were immunised, versus the target

- How did Gavi support mitigate the primary factors underlying low immunisation rates

Through:
- Staff capacity-building
- Availability of vaccines and supplies
- Improvements to vehicles and cold chain
- By targeting districts and/or population groups with the lowest coverage rates (including informal dwelling areas, gold panning sites, etc)

- Indicate whether these activities are still relevant, realistic and correctly prioritised in light of the situation analysis that was conducted, and the financial absorption and implementation rates.

Yes, the activities are relevant because implementation made it possible to achieve significant results (physical completion rate of 94%), with a financial absorption rate of 95%.

- *Provide information on plans aiming to address implementation bottlenecks, specifically planned budget reallocations (please attach the revised budget).*

Identify bottlenecks:
Institutional
- disbursement delays;
- country-wide administrative procedures that influence the disbursement rates;
- difficulties related to public contract procedures;
- failure to understand Gavi's management requirements;
- lack of coordination between the PADS and the entities that implement EPI activities.

Solutions:

- Burkina Faso has agreed to Gavi's management requirements.
- An effective coordination mechanism has been implemented.
- Orders for supplies and inputs will now go through UNICEF and will include all necessary specifications.

- *If applicable, briefly describe the manner in which performance-based funding that the country received was used, and its results. What indicators in the Grant Performance Framework (GPF) will be used to monitor progress?*

These activities were planned according to the HSS2 objectives (see table above).

The PADS is the fiduciary management unit for the Ministry of Health's external funds. It is the entity that ensures financial management of Gavi support and of all other funds contributed by partners. The PADS ensures that there is no duplication of funding or activities but it promotes complementary activities.

The PADS' funding mechanism is as follows: execution entities and programmes submit their annual action plans, which are funded through implementation agreements.

Although the financial management system is satisfactory overall, it could be improved by the drafting of reports separated by type of fund for NVS funds. This issue will be resolved when a dedicated account for Gavi funds is opened, and the software (Tom2Pro) will be configured to reflect this requirement.

In the context of relevant initiatives not supported by Gavi, we note support from the AMP to reduce missed opportunities for immunisation, support from UNICEF for immunisation coverage and equity, from the WHO/CDC for surveillance of vaccine-preventable diseases, and from the CDC for studies.

4.3. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)

Burkina Faso's application was accepted in 2017 by the independent review committee.
An operational deployment plan for equipment was prepared following an evaluation mission to the 605 sites that were selected. That plan was sent to the procurement division at UNICEF Copenhagen, which approved it.

A total of 2,624 pieces of equipment are expected over three years (2018-2020). For the first phase, 605 TCW 40 SDD solar refrigerators are expected out of 1,263 projected for 2018, a gap of 658.

The CCEOP platform will undoubtedly contribute to improved availability and storage of EPI inputs in the health centres.

The country is requesting technical and financial assistance for implementing platform activities in 2019.

4.4. Financial management performance

- HSS absorption rates are satisfactory (95.29% or US$ 1,366,729 spent, out of US$ 1,434,312) and weak for NVS (33.51% or US$ 1,085,408 spent, out of US$ 3,239,032). This disparate performance is caused by outstanding HSS purchases being handed over to UNICEF, as recommended in the most recent JA. The low NVS absorption rates are caused by funds carried over from the 2014, 2015, 2016 and 2017 campaigns. Burkina Faso has requested to use these funds, which are still an integral part of the upcoming HSS3 budget.
- The financial reports meet audit requirements.
- The findings of the 2016 accounts audit resulted in a qualified certification (audit report conferred). The 2017 audit report is not yet available due to delays in selecting an audit firm.
- In 2015, a Gavi audit showed insufficient supporting documentation for expenses, as well as ineligible expenses, totalling US$ 395,699. Gavi was reimbursed for this amount in September 2017.
- The Health Development Support Programme PADS, a Ministry of Health unit that manages external funding, manages Gavi funds through regular accounting using the TOMPRO software and providing twice-yearly financial reports. This accounting is performed according to SYSCOHADA and IFRS standards. Activity execution structures and programmes submit their annual action plans, which are funded through implementation agreements signed for this purpose. Although the financial management system is satisfactory, it could be improved by the drafting of reports separated by type of fund for NVS funds. This issue will be resolved when a dedicated account for Gavi support is opened, and the software will be configured to reflect this requirement.
- Construction project for a new warehouse is being finalised.

4.5. Transition planning (if applicable, eg country is in accelerated transition phase)

- The country is not in a transition process.

4.6. Technical assistance

Technical assistance needs

- Implementation of recommendations from the country-wide immunisation equity analysis (long-term staff).
- Implementation of the measles/rubella monitoring campaign (short-term consulting).
- In-depth EPI review in 2019 (cMYP revision in 2016-2020) (medium-term consulting) – monitoring of vaccine-preventable diseases (long-term staff).
- Implementation of innovative and targeted approaches, specifically in unsafe zones (long-term staff).
- Implementation of an electronic immunisation registry (contract with an implementation entity).
- Capacity-building for DPI staff (MLM for managers and targeted modules for field workers) (short-term consultancy).
- CCOEP implementation (long-term staff).
- Vaccine quality monitoring (short-term consultancy).
- Study on MR vaccine effectiveness (short-term consultancy).
- Communication and demand generation: institutional and logistical support (DPI, DRS, districts), political advocacy support (president selected as immunisation champion), and strengthening community demand (long-term staff).
- Waste management (short-term consulting).
- Immunisation action research (short-term consulting).
- Data quality improvement (long-term staff).
- DVD/MT/DHIS2 transition (long-term staff)
- Support to PADS.

Difficulties encountered:

- Failure to comply with the activity schedule, often related to schedule conflicts; lack of communication; delayed resource allocation, etc.

Amendments/changes:

- Implementation of a technical assistance framework associated with a monitoring mechanism.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status	Comments
1. The national platform for NGOs and associations that support vaccines and immunisation should in the future work more closely with the DPI, the regional and district health entities, management committees and towns to implement activities that benefit immunisation.	Completed	Six platform activities involved the DPI. Field activities to raise awareness involved actors at the peripheral level.
2. Allow the DPI authority to cover the operational and maintenance costs of immunisation support activities (resupplies of inputs, supervision and training of actors in immunisation, cold chain equipment).	Ongoing	Project to review the ruling that creates and governs advance payments – in progress.
3. Set up a more effective mechanism for coordinating and monitoring Gavi-funded activities for better absorption of financial resources.	Not completed	Focal points have been identified.
4. Create a national entity in charge of directing maintenance policies for equipment and health infrastructure.	Completed	Create a directorate for infrastructure and maintenance.
5. Conduct a national level study on equity in immunisation.	Not completed	Currently planning scale-up

Additional significant IRC/HLRP recommendations (if applicable)	Current status	
None		

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 6 below).

Activities that have not been completed and are still relevant will be rescheduled. The reasons for this are included in the Comments column

Assessment of the implementation of the major activities from 2017

Healthcare work force		Current status	Comments
Key finding 1	Staff EPI management skills are improved	Partially completed	Specific supervisions not conducted at the region and district level due to lack of funding
Agreed country actions	- Training of immunisation workers - Specific supervision at all levels		
Associated timeline	2017		
Technical assistance needs	No		
Supply chain			
Key finding 2	The new maintenance system performs well	Partially completed	Spare parts in the process of being purchased
Agreed country actions	- Implement the strategic maintenance plan - Make spare parts available - Train users		
Associated timeline	Q1 2018		
Technical assistance needs	No		
Key finding 3	Central and regional cold rooms are functional	Partially completed	- Relay generators, regulators and extinguishers not purchased - MultiLogs being installed Purchase planned in HSS3
Agreed country actions	- Purchase 13 office computers to install multilogs in regional warehouses - Purchase a relay generator to connect cold rooms to the central storehouse - Purchase voltage regulators for cold chain equipment - Purchase and install multilogs - Train users - Purchase and install fire extinguishers - Train workers		
Associated timeline	Q1 2018		
Technical assistance needs	No		
Key finding 4	Transport logistics for supplies and the outreach strategy is strengthened	Ongoing	Purchase planned in HSS3 Purchase 340 motorbikes
Agreed country actions	- Purchase a 20T refrigerated truck for the central storehouse - Purchase a 20T refrigerated truck to transport supplies		

	- Purchase 500 motorbikes for the outreach strategy		
Associated timeline	Q4 2018		
Technical assistance needs	No		
Key finding 5	Cold and dry storage capacities at the central storehouse are sufficient	Not applicable	Warehouse construction planned. Activity no longer valid
Agreed country actions	- Mobilise resources - Purchase two 80m3 positive cold rooms - Build a storehouse for supplies		
Associated timeline	Q4 2018		
Technical assistance needs	No		
Demand generation/demand for immunisation			
Key finding 6	All children complete their series of immunisations during the year in regions with low coverage	In progress	- Plan to reduce missed opportunities for immunisation - Preparation of an outreach strategy improvement plan - Reorganisation of the DPI with designated focal points responsible for immunisation offerings and results analysis - Project to complete an immunisation equity analysis at the national level - Project to strengthen ownership of the EPI, by DRSs and MCDs
Agreed country actions	- Improve planning and implementation of immunisation activities (fixed-location/outreach) - Improve searches for those lost-to-follow-up - Reach children in specific zones (informal settlements, gold mining sites) - Improve governance - Improve community, town and civil society participation in immunisation activities		
Associated timeline	2017-2018		
Technical assistance needs	No		
Key finding 7	MR2 immunisation coverage is improved	Completed	
Agreed country actions	- Combine MR2 immunisation with MenA - Conduct a research action to measure the impact of the strategy combining MenA and MR2 administration		

Associated timeline	Q1 2018		
Technical assistance needs	Collaboration with CDC/WHO/Gavi/UNICEF		
Leadership, management and coordination			
Key finding 8	Gavi-funded activities are implemented jointly by all actors involved	Not applicable	Planned in HSS3
Agreed country actions	- Organise a joint planning workshop every year - Organise two joint programme monitoring visits - Organise two joint biannual status workshops		
Associated timeline	October 2017-December 2021		
Technical assistance needs	No		
Key finding 9	The quality of immunisation and surveillance data should be improved	Ongoing	Training and supervision not yet completed
Agreed country actions	- Develop an immunisation and surveillance data quality improvement plan - Train workers responsible for managing surveillance and immunisation data - Supervise workers trained in surveillance and data management - Provide health facilities with data management tools		
Associated timeline	Q3 2017-2018		
Technical assistance needs	Developing the plan, modules and training		
Public financial management			
Key finding 10	Funding for vaccine procurement is ensured	Partially completed	Single-tranche disbursement not yet happening
Agreed country actions	- Advocate for increasing the budget item allocated to vaccine procurement - Plan to release the budget item in a single tranche		
Associated timeline	Q1 2018		
Technical assistance needs	No		
Key finding 11	Funding for immunisation support activities should be ensured by the government budget	Not completed	An evaluation of annual support activity costs has been done
Agreed country actions	Conduct advocacy to create budget items for support activities		
Associated timeline	Q4 2017		

Technical assistance needs	- Preparation of the advocacy file with WHO (financial sustainability focal point) - Support from partners asked to help with advocacy		
Other critical aspects			
Key finding 12	Support activities for routine immunisation (supervision, communication to boost routine immunisation, etc) are conducted regularly	Ongoing	The SPONG (a civil society organisation for immunisation) held an innovating finance seminar Advocacy activities to be conducted jointly with civil society in the context of the new DPI roadmap
Agreed country actions	- Local mobilisation of resources to support immunisation - Collaborate with civil society to establish an advocacy programme for immunisation funding		
Associated timeline	2018		
Technical assistance needs	Yes		
Key finding 13	A national strategic plan for managing immunisation waste, including the disposal of cold chain equipment, is implemented	Partially completed	A plan exists within the Department of Health Promotion and Education but has not been implemented
Agreed country actions	- Develop a national strategy for managing immunisation waste, including discarded cold chain equipment - Mobilise resources - Implement the plan		
Associated timeline	Q1 2018		
Technical assistance needs	Expertise for analysing the situation		

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for 2019:

Healthcare work force	
Key finding/Action 1	**Staff EPI management skills are improved at all levels**
Agreed country actions	- Preparation and implementation of the EPI public training workshop plan (MLM) for DPI staff; DRS; SLM; MCD; JCP; EPI district and regional coordinators; CSPS immunisation staff. - Once per month, supervise health workers on EPI management (specific supervision).
Associated timeline	2019
Technical assistance needs	Yes – WHO consulting for six months - Preparing training modules - Implementation of training
Supply chain	

Key finding/Action 2	**Equipment maintenance is ensured**
Agreed country actions	- Ensure preventive and corrective maintenance of equipment at the central and regional level.
Associated timeline	Continuous
Technical assistance needs	Yes – short term; UNICEF three months -For equipment setup, monitoring of operations and repairs
Key finding/Action 3	**Central and regional cold rooms operate correctly**
Agreed country actions	- Purchase relay generators to connect cold rooms to the central storehouse - Purchase voltage regulators for cold rooms at the central and regional level
Associated timeline	Q1 2019
Technical assistance needs	No
Key finding/Action 4	**Transport logistics for supplies and the outreach strategy is strengthened**
Agreed country actions	- Purchase a 10T refrigerated truck for the central storehouse - Purchase a 10T truck to transport supplies - Purchase 500 motorbikes for the outreach strategy
Associated timeline	Q4 2019
Technical assistance needs	No
Key finding/Action 5	**Cold and dry storage capacities at the central storehouse are sufficient**
Agreed country actions	- Build a new warehouse for storage of vaccines and supplies at the central level - Install 70 solar refrigerators
Associated timeline	Q4 2019
Technical assistance needs	Yes – Long-term UNICEF staff to design and monitor warehouse construction
Key finding/Action 6	**CCEOP activities are implemented**
Agreed country actions	- Organise meetings to evaluate sites - Prepare operational deployment plan
Associated timeline	Q2 2019
Technical assistance needs	Yes – Long-term UNICEF staff
Key finding/Action 7	**The 2019 Forecast is available**
Agreed country actions	- Organise a workshop to draft the 2019 Forecast
Associated timeline	Q3 2019
Technical assistance needs	No
Demand generation/demand for immunisation	
Key finding/Action 8	**Immunisation service provision is strengthened**
Agreed country actions	- Provide health facilities with fuel for the outreach strategy and to actively search for dropouts. - Organise catch-up activities in specific zones (poor areas, gold panning sites). - Hire OBCEs to implement immunisation support activities in low-performing districts.

	- Organise a national immunisation support advocacy session with municipalities, civil society, the private sector and potential local philanthropists.
	- Build communication capacity at all levels (DPI, DRS, districts) - Provide facilities with educational media and other communication tools
Associated timeline	2018 -2019
Technical assistance needs	Yes – Long-term UNICEF staff
Leadership, management and coordination	
Key finding/Action 9	**The NITAG's institutional and operational capacities are improved**
Agreed country actions	- Improve NITAG members' capacities - Implement NIGAT action plan
Associated timeline	2019-2020
Technical assistance needs	Yes – to accompany the NITAG
Key finding/Action 10	**Gavi-funded activities are implemented jointly by all actors involved**
Agreed country actions	- Organise a joint planning workshop every year - Organise two joint programme monitoring visits - Organise two joint biannual status workshops
Associated timeline	2019 to 2020
Technical assistance needs	Yes – to accompany the NITAG
Key finding/Action 11	**The quality of immunisation and surveillance data is improved**
Agreed country actions	- Train district EPI coordinators in immunisation data management and surveillance of vaccine-preventable diseases. - Hold a data validation workshop at the district and regional levels. - Train EPI coordinators in immunisation data analysis. - Develop the electronic immunisation registry. - Ensure transportation of samples for diseases under surveillance. - Surveillance of vaccine-preventable diseases – implementation of innovative and targeted approaches – specifically in unsafe zones (ISS, e-surveillance, AVADAR).
Associated timeline	2019
Technical assistance needs	Yes - Sign a contract with an implementation entity for the electronic registry - Long-term staff for surveillance of vaccine-preventable diseases and extension of innovative approaches.
Public financial management	
Key finding/Action 12	**Availability of immunisation inputs is ensured**

Agreed country actions	- Hold monthly meetings for the unit responsible for monitoring the supply of immunisation inputs. - Advocate for increasing the budget item allocated to vaccine procurement. - Ensure that regions are resupplied with vaccine.
Associated timeline	Ongoing
Technical assistance needs	No
Key finding/Action 13	**Funding for immunisation support activities is ensured by the government budget**
Agreed country actions	- Advocate for the creation of budget line items for support activities.
Associated timeline	2019
Technical assistance needs	- Yes. Preparation of the advocacy file with WHO (financial sustainability focal point) - Support from partners asked to help with advocacy
Other critical aspects	
Key finding/Action 14	**An operational plan for immunisation waste management is implemented**
Agreed country actions	- Prepare and implement an annual operational plan for management of immunisation waste. - As soon as possible, destroy immunisation waste from previous campaigns that has accumulated in the districts.
Associated timeline	2019
Technical assistance needs	No
Key finding/Action 15	**Regional and district coordinators are more supportive of immunisation**
Agreed country actions	- Visit workplaces in every region - Train regional directors and chief district physicians in immunisation management, strategies, and worldwide routine immunisation practices (GRISP). - Improve operational capacities in the new office in charge of immunisation offerings
Associated timeline	2019
Technical assistance needs	No

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

Extraordinary ICC meeting to validate the Joint Appraisal: planned for 13 July 2018

8. ANNEX: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) Reporting against all due indicators	x		
Financial Reports			
Periodic financial reports	x		
Annual financial statement	x		
Annual financial audit report	x		
End of year stock level report (which is normally provided by 15 May as part of the vaccine renewal request) *			
Campaign reports*			
Supplementary Immunisation Activity technical report			x
Campaign coverage survey report			x
Immunisation financing and expenditure information		x	
Data quality and survey reporting			
Annual data quality desk review	x		
Data improvement plan (DIP)	x		
Progress report on data improvement plan implementation			x
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)	x		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
CCEOP: updated CCE inventory	x		
Post-Introduction Evaluation (PIE)		x	
Measles & rubella situation analysis and 5-year plan	x		
Operational plan for the immunisation programme	x		
HSS end-of-grant evaluation report	x		
HPV-specific reports			x
Reporting by partners on TCA and PEF functions			

In case any of the required reporting documents is not available at the time of the Joint Appraisal, inform when the missing document/information will be provided.

The MenA PIE report is not on the portal because it was not submitted to the ICC meeting planned for July 2018.