**Application Form for Country Proposals**

*Providing approximately two years of support for an HPV Demonstration Programme*

**Deadline for submission: 15 September 2013**

Submitted by:

The Government of **BURUNDI**

Date of submission: **September 14, 2013**

Please submit the Proposal using the form provided.

Enquiries to: proposals@gavialliance.org or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public. The Proposal and attachments must be submitted in English, French, Spanish, or Russian.

Note: Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline.

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

**GAVI ALLIANCE**

**GRANT TERMS AND CONDITIONS**

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country.

***FUNDING USED SOLELY FOR APPROVED PROGRAMMES***

The applicant country (“Country”) confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

***AMENDMENT TO THIS PROPOSAL***

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

***RETURN OF FUNDS***

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

***SUSPENSION/ TERMINATION***

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

***ANTICORRUPTION***

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

***AUDITS AND RECORDS***

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

***CONFIRMATION OF LEGAL VALIDITY***

The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country’s law, to perform the programmes described in this application.

***CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARENCY AND ACCOUNTABILITY POLICY***

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

***ARBITRATION***

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in this application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

***USE OF COMMERCIAL BANK ACCOUNTS***

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

1. Application Specification

**Q1.** Please specify for which type of GAVI support you would like to apply to.

|  |  |  |
| --- | --- | --- |
| **Preferred vaccine****(bivalent (GSK) or quadrivalent (Merck))****See below for more information** | **Month and year of first vaccination** | **Preferred second presentation1** |
| **Cervarix** : **bivalent** | **December 2015**Elections are scheduled in Burundi for June-August 2015. The mobilization effort to introduce the vaccine in 2014 could coincide with the pre-election campaign.  | **quadrivalent: Gardasil** |

Please summarize the rationale for choice of preferred vaccine. Also, please clarify whether the vaccine is licensed for use in the country.

Selection was based on the following criteria:

1. Vaccine quality (vaccine pre-qualified by WHO and UNICEF)
2. Vaccine effectiveness (ability to prevent the virus serotypes predominantly found in uterine cervix cancer in Burundi)
3. Cold chain (storage volume per dose)
4. Cost:
* Considering the strains present in Burundi, including 16, 18, and 45;
* Considering the cold chain and storage volumes in the districts and at health centers;
* Considering the prospect of reducing the number of doses per girl under the current immunization schedule (from 3 to 2);
* Given that WHO and UNICEF pre-qualified products are used in Burundi’s health care system without problem;
* Based on the vaccine's effectiveness and the country’s economic context, **Cervarix was selected** as the preferred vaccine in Burundi.

For more information on vaccines: <http://www.who.int/immunization> standards/vaccine quality/PQ vaccine list en/en/index.html

1 This “**Preferred second presentation**” will be used in case there is no supply available for the preferred presentation of the selected vaccine (“**Vaccine**” column). If left blank, it will be assumed that the country will prefer waiting until the selected vaccine becomes available.

1. Executive Summary

**Q2.** Please summarize the rationale and the expected outcome of the HPV Demonstration Programme Plan.

Cervical cancer is a public health problem in Burundi. It is the most common form of gynecological cancer in Burundi and the leading cause of cancer deaths among women. Cervical cancer has the highest morbidity-mortality rate due to the absence of a screening program and the lack of adequate care for cancer patients (over 70% of women come for consultation at the inoperable stage) (hospital data).

 The Ministry of Public Health and AIDS Control (MSPLS) has placed special emphasis on cervical cancer prevention and treatment, with primary prevention (immunization and screening) playing a crucial role.

 The HPV Demonstration Programme in Ngozi district in Ngozi province in the north and in Rumonge district in Bururi province in the south will support these efforts.

1. Immunisation Programme Data

**Q3.** Please provide national coverage estimates for DTP3 for the two most recent years from the WHO/UNICEF Joint Reporting Form in the table below. If other national surveys of DPT3 coverage have been conducted, these can also be provided in the table below.

|  |
| --- |
| **Trends of national DTP3 coverage (percentage)** |
| **Vaccine** | **Reported** | **Survey** |
|  | 2011  | 2012  |  2011  | ENCV 2012  |
| DTP3 | 107% (JRF) |  102% (JRF) |  - | 96% |

**Q4.** If survey data is included in the table above, please indicate the years the surveys were conducted, the full title, and if available the age groups the data refer to.

**Survey of routine immunization coverage and following a measles vaccination campaign coupled with the delivery of vitamin A, albendazole, and praziquantel: Burundi, September 2012 (ENCV 2012). Age cohort covered under the survey: 12-23 month old children for routine immunization. Data was confirmed by 2012 WHO/UNICEF estimates (99%).**

**Note:** The IRC may review previous applications to GAVI for a general understanding of country's capacities and challenges.

1. HPV Demonstration Programme Plan

4.1 District(s) profile

**Q5.** Please describe which district or districts have been selected for the HPV Demonstration Programme, completing all components listed in the table below. Also, kindly provide a district level map of the country.

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1** NGOZI  | **District 2 (if applicable)** RUMONGE |
| Topography (% urban, % semi-urban, % rural, % remote, etc.) | urban: 16.08%, rural: 83.92%. source: 2008 GPS [Gen. Pop. Survey] | urban: 13.77, rural: 86.23%. source: 2008 GPS  |
| Number and type of administrative subunits, e.g., counties, towns, wards, villages  | 3 communes, 109 *collines* [hills] source: ISTEEBU | 3 communes, 69 *collines*source: ISTEEBU |
| Total population | 299 858 source: 2008 GPS, based on estimates | 315 422, source: 2008 GPS, based on estimates |
| Total female population (%) | 153 827 (51.3%), source: 2008 GPS, based on estimates | 160 960 (51.01%), source: 2008 GPS, based on estimates |
| Total female population aged 9-10 years (% of total female population) | 22 941 (14.9%), source : UNESCO 2013 and 2008 GPS | 25 316 (15.7%), source: UNESCO 2013 and 2008 GPS |
| Number and type of public health facilities  |  19 health facilities (FOSA), incl. district hospital. source: MSPLS |  17 health facilities (FOSA), incl. district hospital. source: MSPLS |
| Number and type of health workers in all district public health facilities | Physicians: 0Registered nurses: 7A1 nurses: 3A2 nurses: 24A3 nurses: 50source: DSINI data. | Physicians: 0Registered nurses: 0A1 nurses: 0A2 nurses: 11A3 nurses: 68source: DSINI data. |
| Number and type of private health facilities  |  11 private health care facilities. source: MSPLS | 34 private health care facilities. source: MSPLS |
| Number and type of health workers on staff in private health facilities in the district | Physicians: 9Registered nurses: 6A1 nurses: 5A2 nurses: 24A3 nurses: 16source: DSINI data. | Physicians: 4Registered nurses: 3A1 nurses: 7A2 nurses: 25A3 nurses: 46source: DSINI data. |
| Number and type of public and private primary and secondary schools | 80 primary schools, including 3 private29 secondary schoolssource: BPSE | 237 primary schools, including 2 private76 secondary schools. source: BPSE |
| Number of teachers in public and private primary and secondary schools | 1,215 primary school teachers and 336 secondary teacherssource: BPSE | 2,272 primary school teachers and 893 secondary teachers source: BPSE |
| Estimates of the number and percent of girls attending school for each of the following ages:9 year old girls10-year-old girls11 year old girls12 year old girls13 year old girls | 9 years: 4523(86.8%)10 years: 4131(91.7%)11 years: 4124(87.6%)12 years: 3820(86.5%)13 years. 3425(85.6%)source: BPSE and Burundi 2010 DHS [Demographic Health Survey] | 9 years: 5949(86.8%)10 years: 5751(91.7%)11 years: 5001(87.6%)12 years 4492(86.5%)13 years: 4123(85.6%), source: BPSE and Burundi 2010 DHS [Demographic Health Survey] |
| Estimates of the number and percent of girls out of school for each of the following ages:9 year old girls10-year-old girls11 year old girls12 year old girls13 year old girls | 9 years: 68810 years: 37411 years: 58412 years: 59613 years: 576source: UNESCO, July 2013 and BPSE | 9 years: 90510 years: 52111 years: 70812 years: 70113 years 694source: UNESCO, July 2013 and BPSE |

**Q6.** Please give a brief description of why this district (or districts) was (were) selected to participate in the HPV Demonstration Programme.

Ngozi and Rumonge districts meet the following criteria:

* Good DTP3 performance (>90%);
* Average-sized districts with a target population of third grade girls (9-13 years old) equal to 10,777 (Year 1) and 11,035 (Year 2);
* Easy physical access, facilitating supervision site visits and transportation of supplies to

healthcare facilities;

* Functional cold chain adequately equipped to receive the required quantities of the HPV vaccine;
* Presence of urban and rural zones in both districts. In the Ngozi health district, the majority of Ngozi commune is urban and the other two communes (Busiga and Ruhororo) are rural. In the Rumonge health district, the majority of Rumonge commune is urban and the other two communes (Burambi and Buyengero) are rural.

**Q7.** Please describe the operations of the EPI programme in the district(s) selected for the HPV Demonstration Programme.

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1 NGOZI** | **District 2 (if applicable) RUMONGE** |
| Number and type of administrative subunits (e.g. health facilities) used for routine vaccine delivery  | 19 health facilities (FOSA) | 27 health facilities (FOSA) |
| Number and type of outreach sessions in a typical month used for routine vaccine delivery | 5 days/month | 5 days/month |
| DTP3 coverage |  100% in 2012 |  116% in 2012 |
| Polio3 coverage  |  100% in 2012 |  115% in 2012 |
| Measles first dose coverage  |  98% in 2012 |  115% in 2012 |
| Pentavalent 3 coverage  |  100% in 2012 |  116% in 2012  |
| TT2+ (pregnant women) |  128% in 2012 |  183% in 2012 |

**Q8.** Please summarize the performance of the district EPI programme as reported in any recent evaluation, for example identifying resources available, management, successes, and challenges.

**EPI Performance**

**Graph 1: Changes in immunization coverage from 2005 to 2012**

From 1985 to 1993, immunization coverage progressed satisfactorily and was always above 80%. Between 1993 and 2001, immunization coverage dropped from 80% to under 60% due to the crisis.

Since 2003, immunization coverage has increased steadily, quickly surpassing 90% for DTP3, as confirmed by a data quality control check in 2006.

In 2010, the DTPHib/HepB3 coverage rate was 96%, the overall dropout rate (BCG-measles) was 9%, and the DTPHib/HepB specific dropout rate was 3%.

Wastage is monitored at the level of health care facilities that deliver immunization services. Vaccine wastage rates and use rates are indicated in the standard integrated monthly reporting form. However, the calculated rates have not yet been incorporated into the health district database, which would facilitate monitoring at the central level. This aspect will be taken into consideration in the standard tools and database review currently underway.

Although DTPHib/HepB3 immunization coverage is satisfactory at the national level, 4 of the 45 health districts have not been able to achieve 80%.

By the end of 2010, TT immunization coverage in pregnant women had reached 94% at the national level.

Lastly, although measles immunization coverage was 92% at the national level in 2010, ten health districts reported coverage rates below 80%.

## Programme Management

The Expanded Programme on Immunization (EPI) falls under the Health Services and Programs Office, which is under the General Office of Public Health, which in turn reports to the Cabinet of the Minister of Public Health.

According to its organizational chart, the EPI operates under the coordination of an EPI manager and an assistant manager. The EPI currently provides the following services:

* Management;
* Logistics;
* Training and supervision;
* Communication and social mobilization;
* Surveillance of EPI target diseases;
* Health Information System.

EPI activities are integrated at all levels. Supportive supervision is one of the key activities of the district health offices (BDS) and each health center is supervised at least once per year. The central level organizes monitoring and evaluation activities quarterly.

At the beginning of each year, the EPI program develops an action plan and annual budget in keeping with the cMYP, which are then submitted for approval by the CPSD [Partnership Framework for Health and Development] (see “Monitoring-Evaluation Mechanisms”). The EPI office oversees implementation and monitoring/evaluation of the plan.

**The main factors leading to improved immunization coverage are:**

* The existence of a large network of healthcare centers (on average, 80% of the population lives within a 5 km radius of a health center);
* The existence of large network of passable roads to facilitate access to healthcare facilities by the population as well as supervision and procurement;
* Over 90% of the country’s health facilities provide routine immunization services;
* Good use of healthcare services;
* Free immunization for children and prenatal care for pregnant women;
* Mother and Child Week has been held semiannually since 2003;
* Integration of EPI activities with other programs (vitamin A, MII, deworming, etc.);
* Existence of a community network (local government and community health workers (CHW));
* Functional cold chain at every level;
* Civil society involvement in immunization services.

**Although effective, Burundi’s EPI has some weaknesses such as:**

* Absence of micro-plans at the intermediate and peripheral levels;
* Dysfunctional coordination bodies at the intermediate and peripheral levels;
* Monitoring/evaluation and supervision guidelines are not integrated or harmonized;
* Absence of a good system for monitoring adverse effects following immunization (AEFI);
* Reach Every District (RED) strategy poorly adapted and implemented at the peripheral level;
* Insufficient supplies at the peripheral level.

**Threats/Constraints:**

* Strong dependence on foreign financing;
* High rate of employee mobility;
* Intense pressure on the district management team (DMT) (overlapping activities);
* Lengthy administrative procedures;

**Q9a.** Please describe any current or past linkages the district EPI programme has had with the primary and/or secondary schools in the district, e.g., going to schools for health education, delivery of vaccinations, outreaches, etc.

 In the context of routine supervision, the central level only reaches the district level. Health centers and schools are reached by the districts.

However, during immunization campaigns, all places are accessible for any of the activities and the collaboration between authorities in the health and education sectors is always one of the guarantees of a successful outcome.

Immunization activities have been conducted in schools along with other context-specific interventions in various different situations such as the polio outbreak response campaign (2009), the Mother-Child Week held every 6 months in Burundi, and National Handwashing Days.

**Q9b.** Please indicate if gender aspects relating to introduction of HPV vaccine are addressed in the demonstration programme?

This demonstration program will cover all out-of school 10-year-old girls and all girls in primary grade 3 from every social class. Boys will not be immunized as part of this demonstration program.

**Q9c.** Please describe any recent evidence of socio-economic and/or gender barriers to the immunisation programme through studies or surveys?

At present, the EPI in Burundi has not encountered any socio-economic barriers. However, rumors may start with the introduction of this vaccine, especially given that the vaccine will cover a new target population (young girls only). During previous TT vaccine campaigns for schoolgirls, some people were reluctant, believing that the intent was to sterilize the girls. The Burundian population has access to all immunization services offered at health facilities free of charge.

* 1. Objective 1: HPV vaccine delivery strategy

**Q10.** Please describe the primary and secondary HPV vaccine delivery strategies selected (school-based, facility-based, outreach, mixed, other, etc.) and the rationale for selection.

**Note:** If the application proposes to use school as a venue for HPV vaccine delivery the minimal proportion of girls of the target vaccination cohort or target grade that is enrolled in school must be 75% nationwide (not only in the selected district).

The primary strategy uses school as a venue, based on grade level, and will cover more than 90.8% of the target cohort. Girls in primary third grade will receive the vaccine at their schools. Out-of-school 10-year-old girls will be immunized through a community-based approach as a permanent strategy at health centers.

This will be supplemented with immunization sessions at fixed sites and as part of outreach strategies to cover the 9.2% of 10-year-old girls not attending school. Community health workers will identify out-of-school girls and direct them to the permanent sites according to a pre-established calendar. Involving representatives of marginalized groups and community health workers will help reach 10-year-old girls from these groups.

**Q11.** If schools are being used as a venue for HPV vaccine delivery, please state the percentage of girls in the target age group which are attending school nationwide and in the district(s).

According to UNESCO data, 87.4% of girls in the 9-13 age cohort are attending school nationwide. In the Ngozi and Rumonge health districts these percentages are 87.7% and 86% respectively.

**Q12.** Please identify a single year of age (or single grade in school) target vaccination cohort within the target population of 9-13 year old girls and provide information in the table below. Please clarify the rationale for the choice of the target population.

|  |  |  |  |
| --- | --- | --- | --- |
| **Target age or grade** | **N. of girls targeted Year 1** | **N. of girls targeted Year 2** | **Source of data** |
| 10-year-old girls or primary grade 3 | 9882  | In school | 10119  | In school | UNESCO Report, July 2013 |
| 10-year-old girls not attending school | 895 | Out of school | 916 | Out of school | UNESCO Report, July 2013 |
|  | 10777 | Total | 11035 | Total | UNESCO Report, July 2013 |

**Q13.** If the target population is a single grade in school, describe the percentage of girls in the target grade which are between the ages of 9 and 13 years and the data source.

|  |  |
| --- | --- |
| Age | Proportion of girls in grade |
| Below 9 | 6.7% |
| 9 | 23.7% |
| 10 | 26.4% |
| 11 | 21.5% |
| 12 | 13.0% |
| 13 | 6.2% |
| Above 13 | 2.5% |
| Total | 100% |

**Note:** If the strategy selects eligible girls based on their grade in school, then at least 80% of the girls in the target age group should be between 9 and 13 years of age (the WHO recommended age group for HPV vaccine).

Girls between 9 and 13 years old in third grade represent 90.8% of the target age group in the two districts.

**Q14.** Please describe how eligible out-of-school girls will be identified and the mechanism for providing them an opportunity to receive HPV vaccine.

Community health workers will identify out-of-school girls and direct them to the permanent sites according to a pre-established calendar. Involving representatives of marginalized groups and community health workers will help reach 10-year-old girls from these groups. To avoid immunizing the non-target group (out-of-district), preprinted cards will be distributed to the girls identified. Girls who are absent on the main vaccination days will be immunized during mop-up sessions held a month after each dosing session.

**Q15.** Please describe the mechanism for reaching all the target girls with three doses who were missed on the main vaccination days, specifying plans for reaching hard-to-reach or marginalized girls.

To deliver the three doses, two consecutive days of vaccination sessions will be held for each round at schools (3rd grade) and at the health centers for out-of-school 10-year-old girls previously identified in the community. For girls who were missed on the main vaccination days, an immunization registry containing the full identification of the girls and their parents will be used along catch-up cards similar to those used with other vaccines for people in the lost to follow-up category.

To catch-up girls who were missed, a second session will be held during the same period at school and at health centers for out-of-school girls. The names and addresses of girls who miss the initial round and girls lost to follow-up will be given to the community health workers and the representatives of vulnerable groups so that they can bring these girls to the health centers on the vaccination day.

Hard-to-reach or marginalized girls will be identified and reached with the help of community health workers and representatives of marginalized groups.

**Q16.** Please summarize ability to manage all the technical elements which are common to any new vaccine introduction, e.g. cold chain equipment and logistics, waste management, vehicles and transportation, adverse events following immunization (AEFIs), surveillance, and monitoring, noting past experience with new vaccine introductions (such as rotavirus, pneumococcal vaccine, or others).

The cold chain is operational at three levels: central, intermediate, and peripheral level.

**At the central level,** the EPI has 4 walk-in cold rooms and 18 freezers that take the place of freezer rooms. Net storage capacity is estimated at 33,334 liters for cold storage and 1,944 liters for freezer storage. Vaccine storage needs (including new vaccines) for the period 2014-2019 will increase from 31,674 liters in 2014 to 35,566 liters in 2019 for cold storage and 1,199 liters for freezer storage, with each antigen being restocked two times per year. Thus, cold and freezer storage capacity is largely sufficient to accommodate the introduction of the HPV vaccine. These devices receive regular periodic maintenance. Three back-up generators equipped with an automatic startup system ensure cold chain operation in the event of a power outage.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |   | **Formulas** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** |
| **A** | Total annual volume of vaccines in cold storage | *Number obtained by multiplying the total number of vaccine doses by the volume per dose* |  31 674 liters |  32 528 liters |  33 293 liters |  33 913 liters |  34 740 liters |  35 566 liters |
| **B** | Net total cold storage capacity in the cold chain | *#* |  33 334 liters |  33 334 liters |  33 334 liters |  33 334 liters |  33 334 liters |  33 334 liters |
| **C** | Estimated minimum number of shipments per year required for actual cold chain capacity | *A/B* | 0,95 | 0,98 | 1,00 | 1,02 | 1,04 | 1,07 |
| **D** | Number of shipments per year | *On the basis of the national vaccine shipment plan* | 2 | 2 | 2 | 2 | 2 | 2 |
| **E** | Difference (if any) | *((A/D) - B)* | **- 17 497 liters** | **- 17 070 liters** | **- 16 688 liters** | **- 16 378 liters** | **- 15 964 liters** | **- 15 551 liters** |
| **F** | Estimated expansion cost | *USD* | $0 | $0 | $0 | $0 | $0 | $0 |

Cold chain capacity required at the central level

**At the intermediate level:**

As the policy to decentralize the healthcare system has been implemented, health reforms have focused on health districts. Activities that were previously under the responsibility of provincial health offices (BPS) are now handled by health districts (BDS), including vaccine management.

With the introduction of the PCV-13 vaccine, each BDS was equipped with a refrigerator (Vestfrost MK 304) and a freezer (Vestfrost MF 304) with enough storage capacity to meet the district’s vaccine storage needs on the basis of one supply shipment per month throughout the 2014-2019 period (taking into account the introduction of new vaccines).

Cold chain capacity required at the intermediate level from 2014 to 2019

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |   | **Formulas** | **RUMONGE** | **NGOZI** |
| **A** | Total annual volume of vaccines in cold storage | *Number obtained by multiplying the total number of vaccine doses by the volume per dose* |  1 205 liters |  1 147 liters |
| **B** | Net total cold storage capacity in the cold chain | *#* |  108 liters |  108 liters |
| **C** | Estimated minimum number of shipments per year required for actual cold chain capacity | *A/B* | 11,15 | 10,62 |
| **D** | Number of shipments per year | *Based on national vaccine shipment plan* | 12 | 12 |
| **E** | Difference (if any) | *((A/D) - B)* | **- 8 liters** | **- 12 liters** |
| **F** | Estimated expansion cost | *USD* | $0 | $0 |

**At the health center level**, of the 830 health centers (CDS) available in 2013, 660 (79.5%) are equipped with various types of functional cold chain equipment. Health centers that still do not have refrigerators will gradually be equipped with them.

Despite the existence of a functional cold chain and good storage capacity, most of the refrigerators run on petroleum. A steady supply of petroleum is not always available at the national level due to constraints such as problems related to procurement procedures, ordering and delivery, etc. This sometimes causes stock-outs and the CDSs are forced to buy their own petroleum, which may be poor quality and can damage the equipment. This constraint will no longer pose a problem, however, when the transition is made from absorption refrigerators to solar refrigerators starting in 2014.

**Q17.** Please describe the cold chain status for the selected district and the data source(s) for this information. Information such as the number of cold storage facilities, function and working order of the facilities, storage capacity (and any excess capacity), distribution mechanism for routine delivery of vaccines, status of vaccine carriers and icepacks (e.g., supply shortages or excesses), and plan for HPV vaccine storage and distribution during the HPV Demonstration Programme.

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1** NGOZI | **District 2 (if applicable)** RUMONGE |
| Number and type of cold storage facilities  | Vestfrost MK304 refrigerator; MF314 freezer(EPI data) | Vestfrost MK304 refrigerator; MF314 freezer (EPI data) |
| Functioning and working order of the facilities | Good condition | Good condition |
| Storage capacity (any excess) | 108 liters: refrigerator271 liters: freezer | 108 liters: refrigerator271 liters: freezer |
| Distribution mechanism | Vaccines initially stored at district level, with supplies sent to health centers monthly  | Vaccines initially stored at district level, with supplies sent to health centers monthly Vehicles/motorcycles/bicycles  |
| Number and status of vaccine carriers  | Each health facility (FOSA) has a minimum of 2 vaccine carriers in good condition | Each health facility (FOSA) has a minimum of 2 vaccine carriers in good condition |
| Number and status of icepacks (any shortages or excess) | excess | excess |

**Q18.** Additional district cold chain information if necessary:

Current cold chain capacity at the district level is sufficient to accommodate vaccines for the demonstration phase. Districts and health centers will be stocked one week prior to each round.

* 1. Objective 1: HPV vaccine delivery training and community sensitisation & mobilisation plans

**Q19.** Please describe initial plans for training of health workers and others who will be involved in the HPV Demonstration Programme.

A series of trainings will be conducted to introduce the new vaccine in the two districts.

A training module will first be developed.

-- training module developed;

-- training for trainers at the central level (MSPLS, MEBSEMFPA [Ministry of Primary and Secondary Education, Trades, Vocational Training, and Literacy], civil society members/representatives of faith-based groups, and other partners);

-- training for management teams from the BPS, BDS, DPE, DCE, and ICE

-- training for incumbents at health centers and vaccinators, primary school principals and teachers, parent committee presidents, community health workers, etc.

**Q20.** Please describe initial communication plans for sensitizing and mobilizing communities for the HPV Demonstration Programme.

In Burundi, as in other countries, introduction of the new HPV vaccine for 9-13 year old girls could encounter obstacles and be met with reluctance on the part of recipients and other community members. Rumors abounded in neighboring Rwanda. People thought the vaccine was intended to sterilize the girls, that their children were being used as guinea pigs for experimentation, etc. The occurrence of AEFI around the injection site made it difficult for districts outside the demonstration program to accept the vaccine. The following strategies will be implemented to reduce these barriers and encourage the support and commitment of all parties to ensure a successful outcome:

* Advocacy,
* Social mobilization/partnerships,
* Social and behavior change communication,
* Capacity-building;
* Production and distribution of communication materials,
* Monitoring and evaluation.

Vaccine promotion activities will be conducted, including informing and educating people about the new vaccine's advantages for community health in general and for young girls/future mothers in particular. Community leader capacities will need to be strengthened to enable them to take ownership of this operation and become more involved in maintaining the populations’ health.

To eliminate these and other barriers, Behavior Change Communication (BCC) strategies will need to be implemented and reinforced, such as:

1. Social marketing / IEC. The objective will be to involve parents, school leaders, and teachers by providing them essential messages (disease, prevention through HPV immunization and its advantages, etc.). These messages can be conveyed in class by teachers and disseminated through the media if need be.
2. Advocacy at every level will target government authorities, religious leaders, local officials, NGOs/associations, and civil society.
3. Social mobilization used to educate the masses (government and school authorities, community leaders, and local populations) when a vaccine is introduced is an approach used in immunization campaigns and will include training for supervisors, social mobilizers and district focal points, the development of education materials, use of media, etc.
4. Pre-tests of messages and communication materials;
5. Final evaluation meetings.

**Q21.** Briefly describe any initial thinking about potential barriers or risks to community acceptance and the process or communication plan that might be used to address this. Consider briefly describing any positive leverage points that might be beneficial for programme implementation to promote acceptability.

A vaccine targeting only girls can be subject to rumors, particularly concerning the sterilization of girls. Experience has shown that when TT vaccine campaigns were conducted in secondary schools to immunize girls of child-bearing age, some girls did not participate in the campaign because of these same rumors.

Neighboring Rwanda experienced the same problem with the introduction of the HPV vaccine.

Rumors began when Rwanda introduced the HPV vaccine: girls would be sterilized; they were being used as guinea pigs to test drugs, etc. Also, the occurrence of AEFI made vaccine acceptance difficult among young girls.

To overcome these barriers, special efforts will be made to promote communication. The process that will be put in place to dispel these rumors includes massive community awareness-raising, involvement of religious and government leaders, and behavior change communication.

The EPI office will develop a communications plan prior to vaccine introduction. Political and administrative authorities will be educated on the seriousness of cervical cancer and the benefits of the vaccine.

Training and informational sessions will be held for educators, teachers, and parent committees to gain their support for the demonstration programme.

Opinion leaders, representatives of vulnerable groups and community liaisons will be called on to help strengthen awareness-raising at the community level.

Civil society organizations will help organize peer education efforts.

Capacity-building for health care providers will place special emphasis on preventing and treating AEFI, as well as the need to inform parents and educators about the possibility of AEFI.

The post-vaccine-introduction evaluation in the demonstration districts will include a communications assessment.

* 1. Objective 1: HPV vaccine delivery evaluation plan

**Q22.** Indicate the agency/person who will lead the evaluation required for the “Learn by Doing” objective.

The agency selected to evaluate the vaccine delivery plan during the first year (after administration of the 3rd dose) is ISTEEBU (Burundi Institute of Statistics and Economic Studies), which has experience conducting major surveys (2008 RGPH, 2010 EDS, 2012 national immunization coverage survey, 2012 PMS survey, etc.) and is the guarantor of survey quality in Burundi.

* 1. Objective 2: Assessment of adolescent health interventions

**Q23.** Please summarize the anticipated activities for the assessment of adolescent health interventions, such as planning milestones, stakeholder meetings, methodology for the assessment, process for identifying a lead for this activity, and the process to involve the TAG in this work.

Considerable thought will be given to integrating adolescent health interventions. The EPI is proposing to work with other MSPLS and MEBSMFPA programs to study the possibility of incorporating IEC on adolescent pregnancy, HIV, contraception, and health education into the Population and Family Life Education Program and the HIV/AIDS program, as well as in primary schools and adolescent follow-up programs.

During the demonstration programme preparation phase:

* a meeting will be held each month from January to June 2016 during the demonstration period. TAG members already in place will be involved in the activities to integrate adolescent health interventions.
* When the demonstration programme concludes, the activity leads will conduct an assessment under the TAG’s supervision to determine how successfully adolescent health interventions were incorporated.
* In addition to the immunization, the assessment will examine other components of adolescent health such as IEC in schools, deworming with albendazole, TT immunization, and youth and adolescent reproductive health.
	1. Objective 3: Development or revision of cancer control or cervical cancer prevention and control strategy

**Q24.** Please summarize the planned activities for the development or revisions of a national cervical cancer prevention and control strategy, such as planning milestones, stakeholder meetings, methodology for developing the strategy, process for identifying a lead for this activity, and the process to involve the TAG in this work.

A partner has been identified to provide technical and financial support for developing

an overall national cancer prevention and control strategy. The following actions will be taken to incorporate cervical cancer prevention into the national cancer control strategy:

* Development of a cancer registry;
* Research data on prevalence of cancer risk factors;
* Introduction of the HPV vaccine into routine EPI;
* Description of early cancer detection activities;
* Treatment of cancer patients: description of professional practices and patient satisfaction.
	1. Technical advisory group

**Q25.** Please identify the membership and terms of reference for the multi-disciplinary technical advisory group established that will develop and guide implementation of the HPV Demonstration Programme and list the representatives (at least positions, and ideally names of individuals) and their agencies.

￻ Countries are encouraged to use their ICC or a subset of the ICC as the multi-disciplinary TAG.

￻ The TAG must at least have representatives from the national EPI programme, cancer control, education, and the ICC (if separate from the ICC), and adolescent and/or school health (if they are represented within the Ministry of Health).

Enter family name in capital letters.

|  |  |  |
| --- | --- | --- |
| **Agency/Organization** | **Name/Title** | **Area of Representation1** |
| Office of Health Programmes and Projects / MSPLS | Dr. Irénée NDABAGIYE  | Director of Health Programmes and Projects / MSPLS |
| Expanded Programme on Immunisation (EPI) / MSPLS | Dr. Boniface MARONKO  | EPI Director |
| Expanded Programme on Immunisation (EPI) / MSPLS | Dr. Josélyne NSANZERUGEZE | EPI Assistant Director |
| National Programme for Reproductive Health (PNSR) / MSPLS | Dr. Juma NDEREYE  | PNSR Director |
| National Integrated Program for Noncommunicable Chronic Disease Control (PNIMCNT) / MSPLS | Dr. Godefroid KAMWENUBUSA  | PNIMCNT Director |
| National Integrated Program for Noncommunicable Chronic Disease Control (PNIMCNT) / MSPLS | Dr. Jeanine AYINKAMIYE  | PNIMCNT Assistant Director |
|  Expanded Programme on Immunisation (EPI) / MSPLS | Dr. Apollinaire NDAYISABA  | Head of the EPI Immunization Division |
| National Integrated Malaria Prevention Program (PNIP) / MSPLS | Dr. Jean Claude NKURUNZIZA | PNILP Director |
| Kamenge CHU (university hospital center) | Dr. Jeanne Odette NIYONGERE | Obstetrician-Gynecologist at the Kamenge CHU, professor at the school of medicine |
| Kamenge CHU (university hospital center) | Dr. Déo NIYUNGEKO | Pediatrician at the Kamenge CHU, professor at the school of medicine |
| Prince Régent Charles Hospital | Dr. Janvier RUKUNDO | Clinician – Emergency Department |
| GAVI HSS “KARADIRIDIMBA Project”  | Dr. Etienne NIYONZIMA  | Assistant Coordinator, GAVI HSS “KARADIRIDIMBA Project”  |
| Ministry of Primary and Secondary Education, Trades, Vocational Training and Literacy (MEBSEMFPA) | Mrs. Joséphine NDAYISHIMIYE  | Adviser to the Office of Planning and Education Statistics (BPSE)/MEBSEMFPA |
| Ministry of Finance and Economic Development Planning (MFPDE)  | Jean Liévin GAKWAVU  | Adviser to the Ministry of Finance and Economic Development Planning (MFPDE) / Budget |
| WHO representative | Dr. Rose Marie Magnifique NDUWIMANA  | EPI / WHO Focal Point |
| UNICEF representative | Dr. Dorothée NTAKIRUTIMANA | UNICEF / EPI Focal Point |
| Representative from Pathfinder | Dr. Déo MBONINYIBUKA | Child health / Pathfinder |
| Representative of civil society organizations (CSO) | Dr. Donavine UWIMANA  | Executive Director, ABUBEF |

1Area of representation includes cancer control, noncommunicable disease, immunisation, adolescent health, school health, reproductive health, maternal or women’s health, cervical cancer prevention, nursing association, physicians, health communications, midwives, civil society group, education, etc.

**Q26.** If known, please indicate who will act as the chair of the technical advisory group.

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name/Title** | **Agency/Organisation** | **Area of Representation** |
| Chair of Technical Advisory Group | Dr. Irenée NDABAGIYE | Office of Health Programmes and Projects / MSPLS | Public health sector |

* 1. Project manager/coordinator

**Q27.** List the contact details, position, and agency of the person who has been designated to provide overall coordination for the day-to-day activities of the two-year HPV Demonstration Programme, taking note that a technical officer/lead/manager from EPI might be most suitable as a part of their current role and responsibilities.

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Dr. Boniface MARONKO  | **Title** | Director, Expanded Programme on Immunisation |
| **Tel no** | (+257)22256414 (Office) / (+257)79928514 (Cell) |
| **Fax no** | [Type text] | **Agency** | Ministry of Public Health and AIDS Control |
| **Email** | bonymaronko@gmail.com | **Address** | Programme Elargi de Vaccination Avenue de l’hôpital, B.P. 160 Bujumbura, Burundi |
|  |  |

**5. Timeline**

The HPV Demonstration Programme will include immunization of the cohort of girls in two consecutive years (Figure I). Countries are required to begin vaccinating in the demonstration district within two years of the application.

**Figure 1. HPV Demonstration Programme timeline**

|  |  |  |  |
| --- | --- | --- | --- |
|  | First round of vaccination | Evaluation of first round | Second round of vaccination |
|  | Assessment feasibility integrated delivery Start cancer control strategy | If feasible, test joint delivery of servicesFinalisation of cancer control strategy |
|  |  |  |  |  |  |  |  |  |  |  |
| Planning | Year 1: demo project implementation | Year 2 |
|  |  |  |  |  |  |  |  |  |  |

**Q28.** Please modify as necessary and complete the timeline below for the main activities for HPV vaccination, assessment of adolescent health interventions, and development/revision of a national cervical cancer prevention and control strategy planned for the HPV Demonstration Programme. Countries should ensure enough time is scheduled for planning activities prior to delivery of HPV1. For programme tracking purposes, Year 1 starts with delivery of the first dose of vaccine. Applicants may want to complete this in MS Excel.

|  |  |
| --- | --- |
|  | **Months of HPV Demonstration Programme** |
|  | **2013** | 2014 | 2015 | 2016 | 2017 | 2018 |
|  **Activity** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 23 4 5  |
| Establish TAG |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Draft implementation plan |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Brief key stakeholders |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Establish implementing team |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Establish team to conduct assessment of ADH interventions |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Establish team to work on cervical cancer strategy |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Adapt IEC materials & communication plan |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Review and revise immunization forms |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Confirm space in district cold store |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Clear vaccine supply from customs |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Develop methodology for assessment of ADH interventions |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Develop training plan |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Develop plan with key stakeholders for process of developing / revising cervical cancer strategy |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Microplanning at district |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Implement training plan |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Implement communication strategy in district |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Transport vaccine to district |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Develop evaluation plan |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Conduct assessment of ADH interventions |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Deliver dose 1 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Mop-up sessions for dose 1 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Deliver dose 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Mop-up sessions for dose 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Deliver dose 3 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Mop-up sessions for dose 3 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Produce draft outline for cervical cancer strategy |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Collect data to evaluate feasibility of joint delivery (adolescent RH, deworming, TT, IEC) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Collect cost data |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Analyze evaluation data |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Write preliminary report of evaluation |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Write preliminary report of feasibility assessment of ADH interventions |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Review results from year 1 and outline any programme delivery changes for year 2, including whether to do joint delivery of HPV vaccine and an ADH intervention |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Submit financial report to GAVI (15 months after funds disbursed from GAVI) |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Submit progress report to GAVI  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| As appropriate, complete and submit GAVI application for national introduction |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Top up training or programme material revisions for year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Microplanning for year 2 delivery |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| If joint delivery done in year 2, revise evaluation plan from year 1 for year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| If joint delivery done in year 2, revise immunization forms, as needed |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Transport vaccine supply to district for year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Implement communication strategy in district |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Prepare first draft of full cervical cancer strategy |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Deliver dose 1 in year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Mop-up sessions for dose 1 in year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Deliver dose 2 in year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Mop-up sessions for dose 2 in year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Deliver dose 3 in year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Mop-up sessions for dose 3 in year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| If no joint delivery, gather routine programme and monitoring reports for synthesis of outputs |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| If joint delivery done in year 2, conduct coverage survey |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| If joint delivery done in year 2, conduct cost analysis |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| If joint delivery done in year 2, collect and analyze feasibility data |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Prepare second draft of full cervical cancer strategy |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Analyze coverage, feasibility and cost data, if joint delivery done in year 2 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Draft evaluation report of year 2 vaccinations |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Final recommendations to TAG and MOH for national scale-up of HPV vaccine, including decision on joint delivery |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Submit financial report to GAVI (12 months after last report) |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Submit final progress report to GAVI  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Submit last draft of cervical cancer strategy to MOH |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |
| Hold dissemination meeting to key stakeholders |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |         |

**6. Budget**

Page **14** of **23**

**Q29.** Please provide a draft budget for year 1 and year 2, identifying activities to be funded with GAVI’s programmatic grant as well as costs to be covered by the country and/or other partner’s resources.

**Note:** If there are multiple funding sources for a specific cost category, each source must be identified and their contribution distinguished in the budget.

|  |  |  |
| --- | --- | --- |
| **Cost Category** | **Funding source** | **Estimated costs per** |
|  | **Year 1** | **Year 2** |
| Microplanning  | GAVI |  395 000  |  -  |
| Procurement of HPV vaccines and vaccination supplies | GAVI + government |  357 125  |  418 916  |
| Training  | GAVI + other local partners |  56 000  |  -  |
| Supervision/Monitoring and evaluation | GAVI |  70 982  |  70 954  |
| Social mobilization and mobilization materials | GAVI + other local partners |  76 127  |  -  |
| Service delivery | GAVI |  432 430  |  432 430  |
| Other recurring costs | GAVI |  1 844  |  2 518  |
| **Total** |  |  **1 389 508**  |  **924 818**  |

7. Procurement of HPV vaccines and cash transfer

HPV vaccines must be procured through UNICEF. Auto-disable syringes and disposal boxes will be provided.

**Please note that**, using the estimated total for the target population in the district and adding a 10% buffer stock contingency, the GAVI Secretariat will estimate supplies needed for HPV vaccine delivery in each year and communicate it to countries as part of the approval process.

**Q30.** Please indicate how funds for operational costs requested in your budget in section 6 should be transferred by the GAVI Alliance (if applicable).

GAVI Alliance will send the funds via bank transfer.

8. Financial Management Arrangements Data Sheet

Q31.

|  |
| --- |
| **Information to be provided by the recipient organization/country** |
| 1. Name and contact information of the recipient organization(s) | **Programme Elargi de Vaccination (PEV)****BP: 160 BUJUMBURA -BURUNDI****Email:****Tel: (+257) 22 22 37 36/22 25 64 14** |
| 2. Experiences of the recipient organization with GAVI, World Bank, WHO, UNICEF, GFATM or other donors-financed operations (e.g. receipt of previous grants)  | **YES** **If YES,** please state the name of the grant, years and grant amount: and provide the following: **For completed Grants:** * What are the main conclusions with regard to use of funds?

**For on-going Grants:** * Most recent financial management (FM) and procurement performance rating?
* Financial management (FM) and procurement implementation issues?
 |
| 3. Amount of the proposed GAVI HPV Demo grant (US Dollars) |  |
| ***4. Information about financial management (FM) arrangements for the GAVI HPV Demo Programme:*** |  |
| * Will the GAVI Demo Programme resources be managed through the government standard expenditure procedures channel?
 | Yes |
| * Does the recipient organization have an FM or Operating Manual that describes the internal control system and FM operational procedures?
 | Yes |
| * What is the budgeting process?
 |  |
| * What accounting system is used or will be used for the GAVI HPV Demo Programme, including whether it is a computerized accounting system or a manual accounting system?
 |  |
| * What is the staffing arrangement of the organization in accounting, auditing, and reporting? Does the implementing entity have a qualified accountant on its staff assigned to the GAVI HPV Demo Programme?
 |  |
| * What is the bank arrangement? Provide details of the bank account at the Central Bank or at a commercial bank proposed to receive GAVI HPV funds and the list of authorized signatories. Include titles.
 |  |
| * In the implementation of the HPV Demonstration Programme, do you plan to transfer funds from central to decentralized levels (provinces, districts etc.)? If yes, how will this funds transfer be executed and controlled?
 |  |
| * Does the implementing entity keep adequate records of financial transactions, including funds received and paid, and of the balances of funds held?
 |  |
| * How often does the implementing entity produce interim financial reports?
 |  |
| * Are the annual financial statements audited by an external audit firm or Government audit institution (e.g. Auditor General Department, etc.)?
 |  |
| ***5. Information about procurement management arrangements for the GAVI HPV Demo Programme:*** |
| * What procurement system is used or will be used for the GAVI HPV Demo Programme?
 |  |
| * Does the recipient organization have a procurement plan or a procurement plan will be prepared for this HPV Demo Programme?
 |  |
| * Is there a functioning complaint mechanism?
 |  |
| * What is the staffing arrangement of the organization in procurement? Does the implementing entity have an experienced procurement specialist on its staff?
 |  |
| * Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?
 |  |

9. Signatures

9.1 Government

The Government of Burundi acknowledges that this Programme is intended to assist the government to determine if and how it could implement HPV vaccine nationwide. If the Demonstration Programme finds HPV vaccination is feasible (i.e. greater than 50% coverage of targeted girls) and acceptable, GAVI will encourage and entertain a national application during the second year of the Programme. Application forms and guidelines are available at <http://www.gavialliance.org>. The data from the Demonstration Programme and timing of a national application are intended to allow uninterrupted provision of vaccine in the demonstration district and nation-wide scale-up.

The Government of Burundi would like to expand the existing partnership with the GAVI Alliance for the improvement of the health of adolescent girls in the country, and hereby requests GAVI support for an HPV Demonstration Programme.

The Government of Burundi commits itself to improving immunisation services on a sustainable basis. The Government requests that the GAVI Alliance and its partners contribute financial and technical assistance to support immunisation of targeted adolescent girls with HPV vaccine as outlined in this application.

The Government of Burundi acknowledges that some activities anticipated in the demonstration programme could be considered research requiring approval by local ethics committees (e.g., collecting data from a random sample of parents of eligible girls for the HPV vaccine coverage survey). We acknowledge we are responsible for consulting and obtaining approval from appropriate local ethics committees (e.g., human subject protection committee or Institutional Review Boards) in our country, as required. By signing this application, the Government of Burundi and the TAG members acknowledge that such approval may be necessary and that it will obtain such approval as appropriate.

The table in Section 6 of this application shows the amount of support requested from the GAVI Alliance as well as the Government of Burundi’s financial commitment for the HPV Demonstration Programme.

Please note that this application will not be reviewed by GAVI’s Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Education or their delegated authority.

**Q32.** Please provide appropriate signatures below.

Enter family name in capital letters.

|  |  |
| --- | --- |
| **Ministry of Public Health and AIDS Control****(or delegated authority)** | **Minister of Primary and Secondary Education, Trades, Vocational Training, and Literacy** (if social mobilization, vaccination or other activities will occur through schools)**(or delegated authority)** |
| **Name** | Honorable Dr. Sabine NTAKARUTIMANA | **Name** | Dr. Rose GAHIRU |
| **Date** |  | **Date** |  |
| **Signature** |  | **Signature** |  |

**Q33.** This application has been compiled by:

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** | **Position** | **Telephone** | **Email** |
| Dr. Boniface MARONKO  | EPI Director | 79 928 514 | bonymaronko@gmail.com |
| Dr. Josélyne NSANZERUGEZE | EPI Assistant Director | 77 730 363 | mamanhygor@yahoo.fr |
| Dr. Jeanne Odette NIYONGERE | Gynecologist at the Kamenge CHU | 79 902 354 | jeanneode@yahoo.fr |
| Dr. Godefroid KAMWENUBUSA  | PNIMCNT Director | 77 737 381 | kamwenubusa.godefroid@yahoo.com |
| Rosine KANEZA | Cabinet Adviser, MSPLS | 78 177 597 | kanezarosine@yahoo.fr |
| Joséphine NDAYISHIMIYE  | Adviser to the Office of Planning and Education Statistics (BPSE)/MEBSEMFPA | 79 491 822 | ndajose2000@yahoo.fr |
| Dr. Christophe NSANZABAGANWA  | WHO consultant | (+250)786553023 | nsanzechrist@yahoo.fr |
| Sylvestre GACECE | Disaster Management Coordinator / Burundi Red Cross regional office | 77 934 316 | sgacece@ymail.com |
| Carinie GASHATO | EPI Secretary | 79 560 820 | calinieg1@yahoo.fr |
| Dr. Aloys NYABENDA | Adviser to the President of Burundi | 79 914 312 | Nyabenda\_aloys@yahoo.com |
| Dr. Apollinaire NDAYISABA  | EPI / Immunization Division | 79 523 970 | aponday5@yahoo.fr |
| Dr. Jeanine AYINKAMIYE  | Assistant Director, PNIMCNT | 79 361 097  | jeanineay@yahoo.fr |
| Jean Liévin GAKWAVU  | Adviser to the Ministry of Finance and Economic Development Planning (MFPDE) / Budget | 79 507 771 | jeanlievingakwavu@yahoo.fr |
| Oda KANYAMUNEZA | Human Resources, Equipment and Transportation Manager / EPI | 79 978 771  | O.kanyamuneza@yahoo.com |
| Dr. Déo MBONINYIBUKA | Children’s Health / Pathfinder | 79 369 062 | mbonideo@yahoo.fr |
| Dr. Sory KOUROUMA | WHO consultant | 71 838 513 | Kouroumasory2002@yahoo.fr |
| Jean Claude MANIRABARUTA | Disease Surveillance / EPI | 79 702 555 | jcmanir@yahoo.fr |
| Dr. Clarisse BUKEYENEZA  | Logistics Manager / EPI | 78 817658 | bukclarisse@yahoo.fr |
| Léonard SIMBIZI | EPI Cold Chain Maintenance Department | 79 931 050 | simbizileon@yahoo.com |
| Dr. Juma NDEREYE  | PNSR Director | 77 732136 | jumandec@gmail.com |
| Dr. Firmin NZOSABA | Service Delivery Manager, EPI | 79 975 118 | fnzosaba@yahoo.fr |
| Désiré NDUWIMANA | EPI Administrative Affairs Division | 79 946 729 | nduwadesire@yahoo.fr |
| Dr. Rose Marie Magnifique NDUWIMANA  | EPI/WHO Focal Point | 79 735106 | nduwimanar@bi.afro.who |
| Donatien NDAYIKEZA | Head of the National Planning Division (MFPDE) | 79 938 291 | ndayidona@yahoo.fr |

9.2 National Coordinating Body – Inter-Agency Coordinating Committee (ICC) for Immunisation

**Q34.** We the members of the ICC, HSCC, or equivalent committee met on 06 September 2013 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

The endorsed minutes of this meeting are attached in Exhibit as DOCUMENT NUMBER: [Type text].

Enter family name in capital letters.

|  |  |  |
| --- | --- | --- |
| **Name/Title** | **Agency/Organisation** | **Signature** |
| Dr. Dieudonné NICAYENZI | Ministry of Public Health and AIDS Control |  |
| Philippe NAKUWUNDI | Ministry of Public Health and AIDS Control |  |
| Dr. Jeanne Odette NIYONGERE | Kamenge CHU |  |
| Dr. Juma NDEREYE  | MSPLS/PNSR |  |
| Dr. Rose M. Magnifique NDUWIMANA | WHO |  |
| Mrs. Annonciate KANYANA | MSPLS/EPI |  |
| Karolina TUOMISMO | WHO |  |
| Dr. Dieudonné NICAYENZI | MSPLS |  |
| Moussa SCINKARD, MSN | Life Net International |  |
| Stéfanie WELLAND | Life Net International |  |
| Dr. Jenine AYINKAMIYE | MSPLS/PNIMCNT |  |
| Dr. Lydie NDORERE | MSPLS/CNTS |  |
| Dr. Clarisse BUKEYENEZA  | MSPLS/EPI |  |
| Dr. Lambert NKURUNZIZA | MSPLS/DSNIS |  |
| Aline NTIBAZONKIZA | CNCA Permanent Secretariat |  |
| Ariane VON MAERCKER | GIZ / Health |  |
| Dr. Firmin NZOSABA | MSPLS/EPI |  |
| Sublime NKINDI | MSPLS |  |
| Dr. Léonce Ngoyagoye | MSPLS |  |
| Désiré NDUWIMANA  | MPSLS/EPI |  |
| Seconde GAHIMBARE | MSPLS/BCAM |  |
| Désiré NDIKUMANA | MSPLS/DGR |  |
| Dr. Alphonse CIZA | WHO |  |
| Guy Boreux  | Belgian Embassy |  |
| Dr. Jean RIRANGIRA | MSPLS/SEP-CNLS |  |
| Dr. Anglebert NICIMPAYE | Belgian Embassy |  |
| Dr. Etienne DEMBELE | UNICEF |  |
| Dr. Dorothée NTAKIRUTIMANA | UNICEF |  |
| Eliane KADIGIRI | JICA |  |
| Dr. Charles BATUNGWANAYO | CELON |  |
| Dr. Etienne NIYONZIMA  | GAVI-HSS Karadiridimba Project |  |
| Dr. Sory KOUROUMA | WHO |  |
| Ahmed Ismail ELMAHS | Egyptian Embassy |  |
| Pasteur Phillipe NAKUWUNDI | MSPLS/BCAI |  |
| Dr. Josélyne NSANZERUGEZE | MSPLS/EPI |  |
|  |  |  |

**Q35.** In case the GAVI Secretariat has queries on this submission, please contact:

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Dr. Boniface MARONKO  | **Title** | EPI Director |
| **Tel no** | (+257)22256414/ (+257)22223736 |
| **Fax no** | [Type text] | **Address** | Programme Elargi de Vaccination/ Avenue de l’Hôpital, BP 160 Bujumbura-BURUNDI] |
| **Email** | bonymaronko@gmail.com |
| **Mobile no** | (+257) 79928514 |  |  |

10. Optional supplementary information

**Q36. (Optional)** If available, countries may provide additional detail in the table below on training content, role, and framework.

|  |  |  |  |
| --- | --- | --- | --- |
| **Who will be trained** | **Role in vaccine delivery (e.g., sensitization, mobilization,***immunization, supervision, monitoring, etc.)* | **Training content***(e.g., basics on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring, etc.)* | **Who will provide the training?** |
| Health workers | [Type text] | [Type text] | [Type text] |
| Supervisors | [Type text] | [Type text] | [Type text] |
| Teachers | [Type text] | [Type text] | [Type text] |
| School officials | [Type text] | [Type text] | [Type text] |
| District leaders | [Type text] | [Type text] | [Type text] |
| Other:  | [Type text] | [Type text] | [Type text] |
| Other: | [Type text] | [Type text] | [Type text] |
| Other: | [Type text] | [Type text] | [Type text] |

**Q37. (Optional)** If available, countries may provide additional detail in the table below on the types of information and/or materials that may be used/disseminated, to which audience, by which mechanism, and the frequency of each.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of information or materials***(e.g., leaflet, poster, banner, handbook, radio announcement, etc.)* | **Audience receiving material***(girls, parents, teachers, health workers, district officials, community groups, etc.)* | **Method of delivery***(e.g., parent meetings, radio, info session at school, house visit, etc.)* | **Who delivers***(e.g., teachers, health workers, district official, etc.)* | **Frequency & Timing***(e.g., daily, weekly, twice before programme starts, etc.; day of vaccination, two weeks before programme begins, etc.; )* |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |
| [Type text] | [Type text] | [Type text] | [Type text] | [Type text] |

**Q38.** **(Optional)** Technical partners (e.g. local WHO staff) are required to participate in planning and conducting the evaluation of HPV vaccine delivery. Please specify if such (an) expert(s) already exist on the country team (name, title, organization). Alternatively, or in addition, an international participant can be requested through technical partners if additional expertise is thought necessary.

[Type text]

**Q39. (Optional)** In the table below, countries can provide a brief summary of the current adolescent health services or interventions and health education activities and implementing agencies in the district selected to implement the HPV Demonstration Programme.

Please add additional tables if necessary.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **intervention** | **intervention** | **intervention** | **intervention** |
| Description of intervention | [Type text] | [Type text] | [Type text] | [Type text] |
| Agency and provider delivering the intervention | [Type text] | [Type text] | [Type text] | [Type text] |
| Target population by age, grade, and sex | [Type text] | [Type text] | [Type text] | [Type text] |
| Number and types of facilities implementing | [Type text] | [Type text] | [Type text] | [Type text] |
| Geographic location(s) of the intervention (where in the country) | [Type text] | [Type text] | [Type text] | [Type text] |
| Timing of the intervention (when) | [Type text] | [Type text] | [Type text] | [Type text] |
| Frequency of the intervention (how often) | [Type text] | [Type text] | [Type text] | [Type text] |
| Coverage of the target population (recent year) | [Type text]year [Type text] data source [Type text] | [Type text]year [Type text] data source [Type text] | [Type text]year [Type text] data source [Type text] | [Type text]year [Type text] data source [Type text] |
| Coordinating agency | [Type text] | [Type text] | [Type text] | [Type text] |
| Collaborating partners | [Type text] | [Type text] | [Type text] | [Type text] |
| Implementation costs of the intervention, if known | [Type text] | [Type text] | [Type text] | [Type text] |
| Funding source, if known | [Type text] | [Type text] | [Type text] | [Type text] |
| Data source(s) for the information on each intervention | [Type text] | [Type text] | [Type text] | [Type text] |

**Q40. (Optional)** Provide a brief summary of the current cervical cancer prevention and treatment services and implementing agencies in the district selected to implement the HPV Demonstration Programme. If available, countries can include information on target populations, delivery structure, and funding sources.

[Type text]

**Q41. (Optional)** Describe the plan for securing Ministry of Health approval of the draft national cervical cancer prevention and control strategy and any activities for dissemination to national, sub-national, and/or local partners and stakeholders.

[Type text]

**Q42. (Optional)** If known, please indicate the representatives of the TAG that will be involved in the assessment of the feasibility of integrating selected adolescent health interventions with delivery of HPV vaccine.

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name/Title** | **Agency/Organization** | **Area of Representation** |
| TAG member involved in assessment of ADH interventions  | Dr. Juma NDEREYE  | PNSR | Director, PNSR |
| TAG member involved in assessment of ADH interventions  | Dr. Jeanne Odette NIYONGERE  | Kamenge CHU | Gynecologist-Obstetrician/ Kamenge CHU |
| TAG member involved in assessment of ADH interventions  | Dr. Donavine UWIMANA  | ABUBEF | Executive Director, ABUBEF |
| TAG member involved in assessment of ADH interventions  | Dr. Janvier RUKUNDO  | Clinician | HPRC |
| TAG member involved in assessment of ADH interventions  | [Type text] | [Type text] |  |

**Q43. (Optional)** If known, please indicate the representatives of the TAG that will be involved in the development or revision of a draft national cervical cancer prevention and control strategy.

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name/Title** | **Agency/Organization** | **Area of Representation** |
| TAG member involved in cervical cancer strategy | Dr. Godefroid KAMWENUBUSA  | PNIMCNT | Director, PNIMCNT |
| TAG member involved in cervical cancer strategy | Dr. Jeanine AYINKAMIYE  | PNIMCNT | Assistant Director, PNIMCNT |
| TAG member involved in cervical cancer strategy | Dr. Jeanne Odette NIYONGERE  | Kamenge CHU | Gynecologist-Obstetrician/ Kamenge CHU |
| TAG member involved in cervical cancer strategy | Dr. Juma NDEREYE  | PNSR | Director, PNSR |

**Q44. (Optional)** If present, please describe the distribution of de-worming medication (anti-helminths) in the district(s).

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1** [Type text] name | **District 2 (if applicable)** [Type text]name |
| Organization of the de- worming programme | [Type text] | [Type text] |
| Lead agency | [Type text] | [Type text] |
| Implementing agency and partners | [Type text] | [Type text] |
| Funding source(s) | [Type text] | [Type text] |
| Frequency and timing of implementation, e.g. twice yearly in March and October | [Type text] | [Type text] |
| Number in target population by age group and sex | [Type text], data source [Type text] | [Type text], data source [Type text] |
| De-worming coverage by age group and sex | [Type text], data source [Type text] | [Type text], data source [Type text] |

**Q45. (Optional)** If present and relevant, please describe any organized semi-annual health days (e.g., Child Health Days) that are currently implemented in the district(s).

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1** [Type text] name | **District 2 (if applicable)** [Type text]name |
| Organization of the semi- annual health days | [Type text] | [Type text] |
| Lead agency | [Type text] | [Type text] |
| Implementing agency and partners | [Type text] | [Type text] |
| Funding source(s) | [Type text] | [Type text] |
| Frequency and timing of implementation, e.g. twice yearly in March and October | [Type text] | [Type text] |
| Services delivered | [Type text] | [Type text] |
| Number in target population by age group and sex | [Type text], data source [Type text] | [Type text], data source [Type text] |
| Coverage of the different services delivered by age group and sex | [Type text], data source [Type text] | [Type text], data source [Type text] |

**Q46. (Optional)** If present, please describe any organized health education programmes implemented at schools and/or in the community that are currently implemented in the district(s).

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1** [Type text] name | **District 2 (if applicable)** [Type text]name |
| Organization of the health education programme  | [Type text] | [Type text] |
| Lead agency | [Type text] | [Type text] |
| Implementing agency and partners | [Type text] | [Type text] |
| Funding source(s) | [Type text] | [Type text] |
| Frequency of services, e.g. once a month, weekly, etc. | [Type text] | [Type text] |
| Services delivered | [Type text] | [Type text] |
| Location(s) of service delivery | [Type text] | [Type text] |
| Number in target population by age group and sex | [Type text], data source [Type text] | [Type text], data source [Type text] |
| Coverage of the different services delivered by age group and sex | [Type text], data source [Type text] | [Type text], data source [Type text] |

**Q47. (Optional)** Please describe if the country intends to conduct other research activities alongside the HPV Demo Programme with funding from other sources.