Gavi

Application Form for Country Proposals

For support for:

New Vaccines Support (routine immunisation)

Submitted by

The Government of

Burkina Faso

Date of submission: **8 September 2015**

Deadline for submission: 29 October 2015

Select Start and End Year of your comprehensive Multi-Year Plan (cMYP)

Start Year	2016	End Year	2020

Form updated in 2015

(To be used with Guidelines dated October 2014)

Please submit the Proposal using the online platform

https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: proposals@gavi.org or representatives of a Gavi partner agency. Unless otherwise specified, the documents can be shared with Gavi partners, collaborators and the 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 Gavi on or before the day of the deadline.

Gavi is unable to return submitted documents and attachments to countries.

Gavi ALLIANCE GRANT TERMS AND CONDITIONS

FINANCING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

The Country will notify Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application. Gavi will provide the necessary documents for the approved change, and the country's request will be duly amended.

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purposes other than for the programmes described in this application, or any Gavi-approved amendment to this application. Gavi reserves the right to terminate its support to the Country for the programs described in this proposal if Gavi Alliance receives confirmation of misuse of the funds granted by Gavi.

ANTI-CORRUPTION

The Country confirms that funds provided by Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its 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 Gavi, as requested. Gavi 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 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 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 Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the Gavi Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either Gavi 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 languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: Gavi 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.

Gavi will not be liable to the country for any claim or loss relating to the programmes described in the 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 its application.

1. Application specifications

Please specify the type of Gavi support you would like to apply for.

Type of support	Vaccine	Start Year	End Year	Preferred second presentation [1]
New Vaccines Support (routine immunisation)	Meningococcal A, 10 dose(s) per vial, LYOPHILISED	2016	2020	
	If the selected vaccine is not your first preference, please state your preferred vaccine and presentation			If the selected vaccine is not your first preference, please state your preferred vaccine and presentation

[1] For a variety of reasons, Gavi may not be in a position to accommodate all countries' first product preferences, and in such cases, Gavi will contact the country to explore alternative options. A country will not be obliged to accept its second or third preference; however, Gavi will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine. If a country does not indicate a second or third preference, it will be assumed that the country prefers to postpone introduction until the first preference is available. It should be noted that this may delay the introduction in the country.

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3. Executive Summary

Please provide a summary of your country's proposal, including the following the information:

- For each specific request, NVS routine support or NVS campaign:
  - Duration of support
  - The total amount of funds requested
  - Characteristics of vaccine(s), if necessary, and the reason for the choice of the format
  - Month and year of planned introduction of the vaccine
- Relevant baseline data, including:
  - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Birth cohort, targets and immunisation coverage by vaccines
- Country preparedness
  - Summary of the EVM assessment report and progress report on the implementation of the planned improvements
- The nature of stakeholders' participation in developing this proposal
  - Interagency Coordinating Committee
  - Partners, including CSO involvement

Vaccine-preventable diseases remain a major public health problem in several developing countries, including Burkina Faso. Burkina Faso has experienced epidemics of meningococcal A meningitis (NmA) on a regular basis.
To combat such epidemics, the country organised a preventive MenAfriVac® campaign across the entire country in December 2010. This campaign covered the population aged 1 to 29 years and immunised over 11,425,391 people.
Following the campaign, a country-wide case-based surveillance system was set up for bacterial meningitis, which revealed an overall reduction in the number of meningitis cases and the near disappearance of NmA as of 2011.
To maintain this achievement, Burkina Faso has decided to introduce the MenAfriVac® vaccine into routine immunisation, with the support of its technical and financial partners including WHO and UNICEF.
The goal of this vaccine introduction is to help eliminate meningococcal A meningitis as a public health problem in Burkina Faso.
The general objective is to strengthen the immunity of children 1-5 years old against meningococcal meningitis type A.

More specifically, this will involve:
- organising a follow-up campaign (mini campaign) to immunise at least 95% of the children 1-5 years old;
- immunising at least 70% of children 15-18 months old during routine immunisation in 2017.

The MenAfriVac® vaccine will be administered at 15 months, in one dose, at the same time as the second dose of the measles-rubella vaccine. Four months before the introduction there will a follow-up campaign (mini campaign) for children 1-5 years old, ie those born between 2010 and 2015 (inclusive).
During the MenAfriVac® introduction, the programme is aiming for the following immunisation coverage rates: 70% in 2017, 90% in 2018 and 100% in 2019.
The programme is also aiming for 100% supplies of vaccines [available] at all levels during the scheduled period.
Before the vaccine is introduced, the EPI management materials will be revised beginning in March 2016, and will incorporate the planned introduction of the inactivated polio vaccine (IPV).
The official launch and introduction of MenAfriVac® into routine immunisation is scheduled for February 2017.
The Expanded Programme on Immunisation (EPI) has successfully launched new vaccines before: DTP-HepB-Hib in 2006, PCV-13 and Rotateq in 2013, and the combined MR vaccine in 2015.
The technical expertise and experience gained in planning, developing guidelines, training, conducting

advocacy and social mobilisation will all be applied to the MenAfriVac® introduction.
Cold chain capacity was strengthened through an equipment rehabilitation and renovation plan that added 160 MK 404 refrigerators, 60 VLS 400 refrigerators and 381 Sibir V170 GE refrigerators to health districts in 2015. However, with the MenAfriVac® introduction an assessment will be conducted to determine the vaccine storage capacities in districts.
The following strategies have been defined so that we can achieve the objectives:
- building health worker competencies
- strengthening EPI logistics capacity
- vaccine and consumable management
- waste management
- revising EPI management materials
- strengthening communication to promote EPI
- AEFI surveillance
- meningitis surveillance
- strengthening the partnership.

The MenAfriVac® introduction will be monitored and evaluated at all levels of the health system (central, regional and district). This will include monitoring immunisation coverage rates, monitoring the number of non-immunised children and conducting a post-introduction evaluation of the vaccine.
The estimated budget for the introduction is CFCA 454,941,236 or US$ 827,166. Gavi is expected to fund US$ 597,889 and the state will contribute US$ 176,727 and other partners will contribute US$ 52,550.
The estimated budget for the catch-up campaign is CFCA 1,698,033,144 or US$ 3,087,333. Gavi is expected to finance US$ 2,571,802. The state will contribute US$ 237,549 and other partners will contribute US$ 277,982.

4. Signatures

4.1. Signatures of the Government and National Coordinating Body

4.1.1. The Government and the Interagency Coordinating Committee (ICC) for immunisation

The Government of Burkina Faso wishes to consolidate the existing partnership with Gavi to strengthen its national routine infant immunisation program and is specifically requesting Gavi support for:

Meningococcal A, 10 dose(s) per vial, LYOPHILISED, routine introduction

The Government of Burkina Faso commits itself to developing national immunisation services on a sustainable basis in accordance with the Comprehensive Multi-Year Plan presented with this document. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Table(s) 6.2.4 in the NVS Routine section of this application shows the amount of support in either supply or cash that is required from Gavi. Table(s) 6.2.3 of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of **December**.

The payment for the first year of co-financed support will be around **December 2016** for meningococcal A, 10 dose(s) per vial, LYOPHILISED.

It should be noted that any request not signed by the Ministers of Health and Finance, or by their authorised representatives, will not be examined or recommended for approval by the Independent Examination Committee (IEC). These signatures appear in Documents Nos.: 1 and 2 in Section 10. Attachments

Minister of Health (or delegated authority)		**Minister of Finance (or delegated authority)**	
Name	Dr Amédée Prosper DJIGUIMDE	**Name**	Jean Gustave SANON
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the Gavi Secretariat has queries on this document):

Full name	Position	Telephone	Email
Dr Mâ OUATTARA	EPI focal point, WHO office	0022670200907	ouattarama@who.int
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Dr Sylvain DIPAMA	Director General of Sector Studies and Statistics	0022670257814	dipamas@yahoo.fr
Dr Sylvain ZEBA	Director of Prevention through immunisation	0022670240561	zebasylvain@yahoo.fr
Mr Charlemagne YODA	PADS Coordinator	0022670750294	charleyod@yahoo.fr
Mr Jean SAWADOGO	Director of Administration and Finance	0022671377599	sawjean19@yahoo.fr

4.1.2. National Coordinating Body/Interagency Coordinating Committee for Immunisation

Agencies and partners (including development partners and NGOs) supporting immunisation services are coordinated and organised through an Interagency coordinating mechanism (ICC, Health Sector Coordinating Committee (HSCC), or equivalent committee). The ICC, HSCC, or equivalent committee is responsible for coordinating and guiding the use of the Gavi NVS routine support and/or campaign support. Please provide information about the ICC, HSCC, or equivalent committee in your country in the table below.

Profile of the ICC, HSCC, or equivalent committee

Name of the committee	Interagency coordinating committee (ICC)
Year of constitution of the current committee	2011
Organisational structure (e.g., sub-committee, stand-alone)	Stand-alone committee
Frequency of meetings	Quarterly

The Terms of Reference or Standard Operating Principles for the ICC, including details on the ICC membership, quorum, dispute resolution process and meeting schedules are presented in the attached document (Document No.: 4).

Major functions and responsibilities of the ICC/HSCC:

The purpose of the ICC is to facilitate permanent coordination between the Government and EPI partners to achieve programme objectives.
The ICC sets the direction of the EPI and controls its use of funds to grow programme performance. It is the decision-making body for managing the funds allocated to immunisation activities, including funds from Gavi.
It reviews and adopts activity programmes to strengthen immunisation services and new vaccine introductions.

Please describe the type of support offered by the different partners in the preparation of this request:

Technical and financial support in developing the main documents (MenAfriVac introduction plan, operating plan of action for the mini catch-up campaign, completing support application forms)

4.1.3. Signature Table for the Coordinating Committee for Immunisation

We, the undersigned members of the ICC, HSCC or equivalent committee *[1]* met on **07/09/2015** to examine this proposal.. At that meeting, we approved this proposal on the basis of the supporting documentation attached. The endorsed minutes of this meeting are attached as document number 5. The signatures confirm the request presented in Document 6 (please use the list of signatures in the following section).

Please refer to Annex C of the Gavi HSS and NVS General Guidelines□™ for more information on ICCs.

Position	Title / Organisation	Name	Please sign below to indicate your attendance at the meeting during which the proposal was discussed.	Please sign below to indicate your approval of the minutes of the meeting during which the proposal was discussed.
Chair	Minister/Ministry of Health	Dr Amédée Prosper DJIGUIMDE		
Secretary	Director of Prevention through immunisation	Dr Sylvain ZEBA		
Members	WHO Representative	Nama Alimatou J DIARRA		
	UNICEF Representative	Marc RUBIN		
	Rotary Representative	Ousmana OUEDRAOGO		
	European Union representative	Absent		
	Agence de Médecins Préventive (AMP) representative	Edouard BETSEM		

	Red Cross representative	Absent		
	General budget directorate representative	Absent		
	Secretary General / Ministry of Health	Djénèba SANON		
	Director of Administration and Finance / Ministry of Health	Jean SAWADOGO		
	Coordinator of Health Development Programme Support (PADS)	Harouna DIARRA		
	Director General of Health/Ministry of Health	Lamoudi YONLI		
	Director General of Sector Studies and Statistics / Ministry of Health	Sylvain DIPAMA		
	Permanent secretary representing NGOs and associations (SPONG)	Oumarou HEBIE		

By submitting the proposal we confirm that a quorum was present. **Yes**

The minutes from the three most recent ICC meetings are attached as DOCUMENT NUMBER: 7).

4.2. National Immunisation Technical Advisory Group (NITAG)

Has a NITAG been established in your country? **Yes**

We the members of the NITAG met on **29/06/2015** to review this proposal. During the meeting we adopted this proposal on the basis of the supportive documentation describing the process for making decisions and recommendations, attached as Document 9.

4.2.1. The NITAG Group for Immunisation

Profile of the NITAG

Name of the NITAG	Technical Advisory Group for Immunisation
Year of constitution of the current NITAG	2014
Organisational structure (e.g., sub-committee, stand-alone)	Stand-alone committee
Frequency of meetings	Quarterly

Position	Title / Organisation	Name
Chair	Neurologist/CHU-YO	Prof Jean KABORE
Secretary	Director of Prevention through immunisation / Ministry of Health	Dr Sylvain ZEBA
Members	Paediatrician/CHU-YO	Prof Ludocvic KAM
	Geneticist/USTA/CERBA/LABIOGENE	Prof Jacques SIMPORE
	Gynaecologist/CHU-YO	Prof Jean LANKOANDE
	Public Health specialist / University of Ouagadougou	Prof Blaise SONDO
	Epidemiologist/Centre Muraz	Prof Nicolas MEDA
	Internal Medicine specialist / INSSA/UPB	Prof Téné Marcelline YAMEOGO
	Biologist / CHUP-CDG	Prof Rama TRAORE/OUEDRAOGO
	Infectious Disease specialist / CHU-YO	Dr S. Rigobert THIOMBIANO

Major functions and responsibilities of the NITAG

This group is responsible for offering scientific and technical support to the health authorities in selecting and implementing national immunisation policies and strategies.

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as

5. Data on the immunisation program

5.1 Reference material

Please complete the tables below, using data from available sources. Please identify the source of the data, and the date. Where possible use the most recent data and attach the source document.

- Please refer to the Comprehensive Multi-Year Plan for Immunisation (or equivalent plan), and attach a complete copy with an executive summary (DOCUMENT NUMBER 11). Please attach the cMYP costing tool (DOCUMENT NUMBER 12).
- Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NUMBER: 14.
- Please refer to the two most recent joint WHO/UNICEF reports on immunisation activities.
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc., as appropriate.
- Please refer to the attached risk assessments in the case of yellow fever and meningitis A mass preventive campaigns.

Please use the most recent data available and specify the source and date.

	Figure	Year	Source
Total population	18,450,494	2015	INSD/GPHC 2006
Birth cohort	811,007	2015	INSD/GPHC 2006
Infant mortality rate	65	2010	DHS-BF 2010
Surviving infants*[1]*	732,675	2015	INSD/GPHC 2006
GNI per capita (US$)	1.215 %	2009	2009 EICVM [Household Living Conditions Survey]
Total Health Expenditure (THE) as a percentage of GDP	12 %	2010	National Health Accounts
General government expenditure on health (GGHE) as % of General government expenditure	29 %	2010	National Health Accounts

[3] Surviving infants = Infants surviving the first 12 months of life

5.1.1 Lessons learned

Support for new routine vaccines

If new or under-used vaccines have already been introduced in your country, please provide details about lessons learned in previous introductions specifically regarding: storage capacity, protection against accidental freezing, staff training, cold chain, logistics, coverage and dropout rates, wastage rates, etc. and propose action areas or give measures taken to address these. Please refer to previous post-introduction evaluations if any. If these items are included in the introduction plan or plan of action, please cite the sections only.

Lessons Learned	Action Points
Coordinating committees need to be set up early on at all levels of the health system	Draft decrees for setting up committees and sub-committees at least six months before the start
Good planning, with the involvement of various stakeholders and partners at all stages, is key for conducting a quality campaign	Micro-planning at all levels followed by arbitration
Coverage rates, wastage rates and AEFIs need to be monitored regularly	Draft guidelines on vaccine and diluent storage, transport and administration at all service provision points Daily debriefing of actors at the operational level
Timely mobilisation of resources leads to a successful introduction	
Cold chain capacity must be assessed and strengthened prior to introducing new vaccines	Rehabilitate, acquire and install new cold chain equipment to fill any gaps

Capacities of stakeholders involved should be strengthened before new vaccine introductions	Train stakeholders at all levels
Targets are better mobilised when communication strategies and messages are adapted to the context and progress of new vaccine introductions	Develop and implement a communication plan at all levels
Management materials and tools must be adapted	Revise management materials and tools

5.1.2- Planning and budgeting of health services

Please provide some additional information on the planning and budgeting context in your country:

The planning and budgeting cycle is annual.

Please indicate the name and date of the relevant planning document for health

2011-2020 National Health Plan (PNDS)

Is the cMYP (or updated Multi-Year Plan) aligned with this document (timing, content etc)?

Yes

Please indicate the national planning budgeting cycle for health

The planning and budgeting cycle is annual.

Please indicate the national planning cycle for immunisation

The planning and budgeting cycle is annual.

5.1.3 Preparatory activities

Please provide a summary of all the **preparatory** activities for the introduction of the vaccine(s) or the campaigns. If they are included in the introduction plan or plan of action, please cite the sections only.

- Programme management and coordination
- Planning and preparation
- Training
- Social mobilisation, IEC, advocacy
- Document reproduction
- Cold chain equipment and maintenance
- Vaccine transport

5.1.4 Gender and equity

Please describe any barriers to access, utilisation and delivery of immunisation services at district level (or equivalent) that are related to geographic, socio-economic and/or gender equity. Please describe actions taken to mitigate these barriers and highlight where these issues are addressed in the vaccine introduction plan(s).

The main potential barriers to immunisation are:
- Rumours and/or poisoning [minds]
- Disinformation
- Variations in immunisation coverage by child's household economic status
- Variations in immunisation coverage by mother's level of education
- Variations in immunisation coverage by birth order or area of residence

To combat possible barriers, activities will be conducted to raise awareness among parents, religious and traditional leaders, and administrative and political authorities.

Please examine whether questions of equity (socio-economic, geographic and gender-specific) factor have been taken into consideration in the process of preparing social mobilisation strategies, among other things, to improve immunisation coverage. Specify whether these issues are addressed in the vaccine introduction plan(s).

The 2010 DHS-MICS in Burkina Faso showed the highest immunisation coverage in the Centre Nord region (94%) and the lowest immunisation coverage in the regions of Sahel and Cascades (66% for both).

Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems.

Sex-disaggregated data have been collected since 2014 in monthly immunisation reports.

Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought or others)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities.

Burkina Faso has had an influx of refugees in the wake of the crisis in Mali. However, the presence of these refugees has not disrupted the immunisation programme.

If possible, please provide additional information and documents on the data relative to sub- national coverage, for example comparisons between urban and rural districts, or between districts with the highest and lowest coverage etc.

The 2010 DHS-MICS in Burkina Faso showed that immunisation coverage is highest in the Centre Nord region (94%) and lowest in the regions of Sahel and Cascades (66%).

Please describe what national surveys are routinely conducted in the country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers.

The 2010 DHS-MICS in Burkina Faso revealed variations in immunisation coverage due to household economic status and area of residence.

5.1.5 Data quality

Please attach a data quality assessment (DQA), report if one has been completed within the previous 48 months (DOCUMENT NUMBER: 13). If available, an improvement plan and progress report on the implementation of the improvement plan should also be submitted (DOCUMENT NUMBER: 16 DOCUMENT NUMBER: 17).

If DQA not available, please briefly describe plans to establish mechanisms for data quality assessment.

Data quality (DQS, LQAS) is assessed twice per year in districts and health regions.
With technical and financial support from WHO, the national level organises:
- data harmonisation every month
- decentralised meetings twice per year
- data validation every year

Please indicate what routine mechanisms to independently assess the quality of administrative data are in place, and if so what these mechanisms are and how they enable the country to track changes in data quality over time.

Routine mechanisms to independently assess the quality of administrative data are in place, including the DHS and in-depth EPI review.

Please detail what household surveys have been conducted in recent years to independently assess immunisation coverage and equity, and describe any survey plans for the coming five year period.

Surveys conducted

- 2009 EICVM [Household Living Conditions Survey]

- 2009 in-depth EPI review

- 2010 DHS-Burkina Faso

Surveys conducted

- Post-campaign evaluation for MR + coverage survey of all EPI antigens

- 2015 in-depth EPI review

5.2. Baseline data and annual objectives (NVS routine immunisation)

Please refer to cMYP pages to assist in filling-in this section.

Number	Base Year	Baseline and Targets			
	2014	2016	2017	2018	2019
Total number of births	784,092	838 895	867 778	897 371	927 894
Total infant deaths	64,805	91 533	105 704	120 226	135 760
Total surviving infants	719,287	747 362	762 074	777 145	792 134
Total pregnant women	977,337	1 045 640	1 081 637	1 156 560	1 156 560
Target population vaccinated with OPV3 *[1]*					
OPV3 coverage *[2]*	103%	100%	100 %	100 %	100 %
Target population vaccinated with DTP1 *[1]*	781,857	747 362	762 074	777 145	792 134
Target population vaccinated with DTP3 *[1]*	741,553	747 362	762 074	777 145	792 134
DTP3 coverage *[2]*	103%	100 %	100 %	100 %	100 %
Wastage *[3]* in base-year and planned thereafter (%) for DTP	3	3	3	3	3
	1.03	1,03	1,03	1,03	1,03
Target population vaccinated with meningococcal vaccine *[1]*	0	0	523154,0	685867,0	777145,0
Meningococcal A coverage*[2]*	0%	0%	69 %	88 %	98 %
First Presentation: Meningococcal A, 10 dose(s) per vial, lyophilised					
Wastage *[3]* rate in base-year and planned thereafter (%)	0	0	50	20	20
Wastage factor [*3]* in base-year and planned thereafter (%)	1.00	1.00	2,00	1,25	1,25
Maximum wastage rate for meningococcal A vaccine, 10 dose (s) per vial, LYOPHILISED	50%	50%	50 %	50 %	50 %
Target population vaccinated with 1st dose of Measles	717,073	747 362	762 074	777 145	792 134
Measles coverage*[2]*	100%	100 %	100 %	100 %	100 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	5%	0%	0 %	0 %	0 %

[1] Indicate total number of children vaccinated with either DTP alone or combined

[2] Number of infants vaccinated out of total surviving infants

[3] The formula to calculate a vaccine wastage rate (in percentage): [(A - B) / A] x 100. Whereby: A = the number of doses distributed for use

according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

Nombre	Données de référence et objectifs
	2020
Total number of births	958 007
Total infant deaths	152 046
Total surviving infants	805 961
Total pregnant women	1 194 062
Target population vaccinated with OPV3 *[1]*	
OPV3 coverage *[2]*	100 %
Target population vaccinated with DTP1 *[1]*	805 961
Target population vaccinated with DTP3 *[1]*	805 961
DTP3 coverage *[2]*	100 %
Wastage *[3]* in base-year and planned thereafter (%) for DTP	3
	1,03
Target population vaccinated with meningococcal vaccine *[1]*	792134,0
Meningococcal A coverage*[2]*	98 %
First Presentation: Meningococcal A, 10 dose(s) per vial, lyophilised	
Wastage *[3]* rate in base-year and planned thereafter (%)	20
Wastage factor [*3]* in base-year and planned thereafter (%)	1,25
Maximum wastage rate for meningococcal A vaccine, 10 dose (s) per vial, LYOPHILISED	50 %
Target population vaccinated with 1st dose of Measles	805 961
Measles coverage*[2]*	100 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %

[1] Indicate total number of children vaccinated with either DTP alone or combined

[2] Number of infants vaccinated out of total surviving infants

[3] The formula to calculate a vaccine wastage rate (in percentage): [(A - B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

5.3. Targets for the preventive campaign(s)

No prevention campaign support this year

6. New and underused vaccines (routine NVS)

6.1. Calculation of the morbidity load for corresponding diseases (if available)

If already detailed in the Introduction Plan or Plan of Action simply cite the section.

Disease	Title of the assessment	Date	Results

6.2. Vaccine requested (Meningococcal A, 10 dose(s) per vial, LYOPHILISED)

As reported in the cMYP, the country plans to introduce meningitis A vaccine, using meningococccal A, 10 dose(s) per vial, LYOPHILISED.

When is the country planning to introduce the vaccine? **February 2017**

Note that due to various factors the launch date may vary from that given in the application. Gavi will work closely with countries and their partners to help address any such situations.

6.2.1. Co-financing information

If you would like to co-finance a larger amount, indicate this in the "your co-financing" line.

Country group	Low income

	Year 1	Year 2	Year 3	Year 4
	2015	2017	2018	2019
Minimum co-financing	0.20	0.20	0.20	0.20
Your co-financing (please change if higher)	0.20	0.20	0.20	0.20

	Year 1
	2020
Minimum co-financing	0.20
Your co-financing (please change if higher)	0.20

6.2.2. Specifications of vaccinations with new vaccine

	Data from		Year 1	Year 3	Year 3	Year 4
			2015	2017	2018	2019
Number of children to be vaccinated with the first dose	Table 5.2	#	0	523,154	685,867	777,145
Immunisation coverage with the first dose	Table 5.2	#	0%	69 %	88 %	98 %
Country co-financing per dose	Table 6.2.1	$	20	0.2	0.2	0.2

	Data from		Year 1
			2020
Number of children to be vaccinated with the first dose	Table 5.2	#	792 134
Immunisation coverage with the first dose	Table 5.2	#	98 %
Country co-financing per dose	Table 6.2.1	$	0.2

6.2.3. Portion of supply to be procured by the country (and cost estimate, US$)

		2015	2017	2018	2019
Number of vaccine doses	#	0	394 500	285 300	312 100
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by country ***[1]***	$	0	262 000	180 000	200 000

[1] The co-financing amount for low-income countries indicates costs for the vaccines and any freight charges. The total co-financing amount does not contain the costs and fees for the procurement agency, such as handling fees. Information about additional costs and fees will be provided by the procurement agency concerned as part of the cost estimate required by the country.

		2020
Number of vaccine doses	#	300 600
Number of AD syringes	#	0
Number of re-constitution syringes	#	0
Number of safety boxes	#	0
Total value to be co-financed by country ***[1]***	$	199 000

[1] The co-financing amount for low-income countries indicates costs for the vaccines and any freight charges. The total co-financing amount does not contain the costs and fees for the procurement agency, such as handling fees. Information about additional costs and fees will be provided by the procurement agency concerned as part of the cost estimate required by the country.

6.2.4. Portion of supply to be procured by Gavi (and cost estimate, US$)

		2016	2017	2018	2019
Number of vaccine doses	#	0	913 600	613 300	688 000
Number of AD syringes	#	0	871 100	806 500	894 300
Number of re-constitution syringes	#	0	145 200	99 800	111 100
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by Gavi	$	0	1 001 500	751 500	846 000

		2020
Number of vaccine doses	#	694 500
Number of AD syringes	#	884 500
Number of re-constitution syringes	#	110 500
Number of safety boxes	#	0
Total value to be co-financed by Gavi	$	860 000

6.2.5. New and Under-Used Vaccine Introduction Grant

Calculation of the vaccine introduction grant for Meningococcal A, 10 dose(s) per vial, lyophilised

Year of New Vaccine Introduction	Births (Table 5.2)	Share per Birth in US$	Total in US$
2016	838 895	0,80	671 116

The Grant will be based on a maximum award of $0.80 per infant in the birth cohort with a minimum starting grant award of $100,000

Please explain how the introduction grant provided by Gavi will be used to facilitate the timely and effective implementation of the activities before and during the introduction of the new vaccine (refer to the cMYP and to the vaccine introduction plan).

The introduction grant will be used to strengthen the competencies of field workers. Additionally, cold chain equipment will be purchased to strengthen logistics.

The 15-month introduction schedule will boost MR2 coverage, especially as the meningitis vaccine is known and accepted by the populations.

Please complete the 'Detailed budget for VIG / Operational costs' template provided by Gavi and attach as a mandatory document in the Attachment section.

Detailed budget attached as Document No. 28.

if the GAVI support does not cover all of the requirements, please describe the other sources of funding and the amounts projected, if available, to cover your requirements

The Government budget will be used to cover other costs.

6.2.6. Technical assistance

Please describe any particular area for which the Ministry will require technical assistance for the meningitis A vaccine introduction.

The Ministry will need technical assistance to conduct the post-introduction evaluation.

7. NVS Preventive Campaigns

No NVS Prevention Campaign Support this year

7.1.1 Epidemiology and disease burden for Meningococcal A

Please select at least one of the following information sources to document the results relative to the disease burden of Meningococcus A:

Epidemiological information on the burden of the disease:

☐ 1 - Risk assessments

☐ 2 - Other

8. Procurement and management

8.1 Procurement and management of routine vaccination with new or underused vaccines

Note: The PCV vaccine must be procured through UNICEF to be able to access the price awarded by the Advance Market Commitment (AMC).

a) Please show how the support will operate and be managed including procurement of vaccines (Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund):

Funds will be managed by the Health Development Support Programme (PADS).

The Department of Prevention through Vaccines (DPV) will schedule activities and send requests to PADS, which will make resources available after reviewing the terms of reference for each activity.

Vaccines and injection materials will be procured through UNICEF.

b) If an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi) is requested, please document

- A description of the mechanism and the vaccines or commodities to be procured by the country
- Assurance that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. For the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, assurance should also be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

Not applicable

c) If receiving direct financial support from Gavi (such as operational support for campaigns or VIG activities), please indicate how the funds should be transferred by Gavi.

Funds should be transferred directly to the PADS account.

e) Please indicate how the co-financing amounts will be paid (and who is responsible for this)

Each year the Ministry of Health Department of Administration and Finance (DAF) wires the necessary funds to the account opened for this purpose in Copenhagen through UNICEF channels. When orders are placed, UNICEF's Supply Division reviews the costs and sends to the Ministry of Health. After proposals are approved the DPV and the DAF give the payment order.

e) Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including procurement.

The applicable management procedures are compliant with country procedures and those in the funding agreement signed between Gavi and the Government of Burkina Faso.

f) Please outline how coverage of the introduced vaccine will be monitored, reported and evaluated (refer to cMYP and Introduction Plan).

Coverage will be monitored via the reporting system that is already in place for other vaccines. Coverage and wastage rates will be calculated monthly at all levels. Monitoring and immunisation coverage graphs will be created at all levels and updated regularly.

Coverage rates at the district level will be reviewed during the ECD-E-ICP Meeting and during district health council meetings, so that facilities with poor performance can be detected and solutions offered.

At the regional level, monitoring will be conducted during meetings of the Regional Health Technical Committee (CTRS).

Progress in coverage rates will be updated regularly at the national level during meetings of the EPI technical support committee (CTA) and the ICC. In addition, decentralised meetings will be organised twice per year with regional directors, district chief physicians and EPI managers in region and district health departments, during which monitoring indicators for the new vaccine will be addressed.

g) If applying for measles second dose, does the country wish to have the support in cash or in-kind? **NA**

8.2 Procurement and management for NVS preventive campaigns

No prevention campaign support this year

8.3. Product licensure

For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines.

Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.

In Burkina Faso, the National Regulatory Authority (NRA) for pharmaceutical products including vaccines is the Directorate General of Pharmacy, Medicines and Laboratories (DGPML).
The DGPML was evaluated by WHO in 2006 as its regulatory functions as NRA were implemented, which provided an assessment of the licensure process in the country. A 2013 assessment by WAEMU classified Burkina Faso as a reference country in terms of health product licensure in the WAEMU zone.
Licensure is required for all products, whether pre-qualified or not. The process includes the following steps:
- Receipt of the dossier
- Evaluation by the committee of experts responsible for evaluating medicines, vaccines and other immunologic products
- Opinion of the Commission for Registering Health Products (CEPS)
- Decision by the Minister of Health.

The process takes a total of 120 days in Burkina Faso.

For each of the vaccine(s) requested, please provide the actual licensure status of the preferred presentation and of any alternative presentations, if required.

MenAfriVac® 10µg, 10-dose vials, was registered under Marketing Authorisation no. 0547920105. The MA is valid from 27 October 2010 until 26 October 2015. A renewal dossier was submitted to the NRA.

Please describe local customs regulations, requirements for pre-delivery inspection, special documentation requirements that may potentially cause delays in receiving the vaccine. If such delays are anticipated, explain what steps are planned to handle these.

EPI vaccines are exempt in Burkina Faso. This exemption is applied properly by the customs service, and there have not been any issues in importing vaccines. Once vaccines arrive at the Ouagadougou airport they are immediately sent to the EPI central depot by the transit agent approved by UNICEF or the Ministry of Health, where they are received and stored in cold rooms regardless of the time of day they arrive.

Please provide information on NRA in the country, including status (e.g. whether it is WHO-certified). Please include points of contact with phone numbers and e-mail addresses. UNICEF will support the process by communicating licensing requirements to the vaccine manufacturers where relevant.

The DGPML was evaluated by WHO in 2006 as its regulatory functions as NRA were implemented, which provided an assessment of the licensure process in the country. A 2013 assessment by WAEMU classified Burkina Faso as a reference country in terms of health product licensure in the WAEMU zone.

8.4 Vaccine Management (EVSM/EVM/VMA)

It is mandatory for a country to conduct an assessment of effective vaccine management (EVM) before requesting support for the introduction of a new vaccine. The EVM a must have been conducted within the preceding 36 months. Please note that this assessment is recommended but not mandatory for requests for operational support to supplemental immunisation campaigns/activities (SIA).

When was the EVM conducted? **August 2012**

Please attach the most recent EVM assessment report (DOCUMENT NUMBER: 25, 26, 27) the corresponding EVM improvement plan (DOCUMENT NUMBER: 26) and the progress report on the EVM improvement plan (DOCUMENT NUMBER: 27). The improvement plan should include a timeline, budget of committed resources for these activities and funding gaps, if any, as well as M&E indicators to monitor progress of implementation.

If any of the above mandatory documents (EVM Assessment Report, EVM Improvement Plan, Progress on the EVM Improvement Plan) are not available, please provide justification and reference to additional documents such as PIE and External EPI Reviews.

When is the next Effective Vaccine Management (EVM) Assessment planned? **November 2015**

NA

8.5 Waste management

Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), the safe handling, storage, transportation and disposal of immunisation waste, as part of a healthcare waste management strategy. Please describe the country's waste management plan for immunisation activities (including campaigns).

In routine immunisation, full safety boxes are collected and stored at health facilities. Those with incinerators destroy them on a regular basis. Those that do not have the safety boxes collected and stored in secure locations by the district management team. Some districts have high-capacity, high-performing incinerators that are used to destroy waste from immunisation. During mass campaigns, all left-over filled boxes are removed and destroyed with the boxes produced during such campaigns, through contracts with private refinery or smelting operators and companies.

9. Comments and recommendations from the national coordinating body (ICC/HSCC)

Comments and Recommendations from the National Coordinating Body (ICC/HSCC)

This request was developed in the context of the 2011-2015 cMYP coming to an end. The 2016-2020 cMYP has been developed with the support of technical and financial partners. It was adopted by the technical committee of the EPI on the instructions of the ICC Chair on October 27, 2015.

10. List of documents attached to this proposal

10.1. List of documents attached to this proposal

Document Number	Document	Section	Mandatory	File
1	MoH Signature (or delegated authority) of Proposal	4.1.1	☑	Signature Ministre de la Santé.jpg **File desc:** **Date/time** 08/09/2015 04:40:42 **Size:** 280 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	☑	Signature Ministre de l'Economie et des Finances.jpg **File desc:** **Date/time** 08/09/2015 04:41:14 **Size:** 280 KB
3	MoH Signature (or delegated authority) of Proposal for assistance to the VPH	4.1.1	☒	No file loaded
4	ICC Terms of Reference	4.1.2	☑	CCIA 2015.pdf **File desc:** **Date/time** 25/08/2015 10:00:02 **Size:** 584 KB
5	Minutes of ICC/HSCC meeting endorsing Proposal	4.1.3	☑	Rapport CCIA AVALISANT.pdf **File desc:** **Date/time** 08/09/2015 10:53:44 **Size:** 2 MB
6	Signatures of ICC or HSCC or equivalent in Proposal	4.1.3	☑	Signatures du CCIA.pdf **File desc:** **Date/time** 08/09/2015 04:41:54 **Size:** 348 KB
7	Minutes of the three most recent ICC/HSCC meetings	4.1.3	☑	RAPPORTS DES 3 DERNIERS CCIA.7z **File desc:** **Date/time** 08/09/2015 11:03:30 **Size:** 4 MB
8	A description of partner participation in preparing the application	4.1.3	☒	No file loaded

9	Minutes of the meeting of the NITAG with specific recommendations on the introduction of the SVN or the campaign	4.2	☒	No file loaded
10	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	☑	GTCV_BFA.pdf **File desc:** **Date/time** 25/08/2015 09:51:15 **Size:** 935 KB
11	comprehensive Multi Year Plan - cMYP	5.1	☑	7.PPAC 2011_2015.doc **File desc:** **Date/time** 25/08/2015 09:48:15 **Size:** 1 MB
12	cMYP Costing tool for financial analysis	5.1	☑	cMYP_Costing_Tool_Vs 2 5_Fr PEV BFA 3_9_2013.xls **File desc:** **Date/time** 04/09/2015 04:51:58 **Size:** 3 MB
13	Monitoring and evaluation and surveillance (M&E) plan for the support requested, within the context of the country's existing monitoring plan for the EPI programme	5.1.5	☑	PLAN DE SUIVI EVALUATION.docx **File desc:** **Date/time** 04/09/2015 12:32:54 **Size:** 70 KB
14	Vaccine introduction plan	5.1	☑	1. Plan_Introduction MenAfriVac_BF_Draft 14 août 2015.docx **File desc:** **Date/time** 02/09/2015 05:38:40 **Size:** 203 KB
15	Introduction Plan for the introduction of RCV / JE / Men A into the national programme	7.x.4	☒	No file loaded
16	Data quality assessment (DQA) report	5.1.5	☒	RAPPORT EVALUATION QUALITE DES DONNEES.docx **File desc:** **Date/time** 25/08/2015 09:55:00 **Size:** 11 KB
17	DQA improvement plan	5.1.5	☒	No file loaded

19	HPV vaccine roadmap or strategy	6.1.1	☒	No file loaded
20	Introduction Plan for the introduction of RCV into the national programme	7.x.4	☒	No file loaded
21	Summary of the methodology of the assessment of the HPV vaccine	5.1.6	☒	No file loaded
22	Evidence of commitment to fund purchase of RCV for use in the routine system in place of the first dose of MCV	7.x.3	☒	No file loaded
23	Campaign target population documentation	7.x.1	☑	CIBLE_MenAfriVac_2016_BFA.xlsx **File desc:** **Date/time** 26/08/2015 07:32:18 **Size:** 13 KB
24	Roadmap or strategy for strengthening a comprehensive approach to pneumonia and/or diarrhoea prevention and treatment	6.x.6	☒	No file loaded
25	EVM report	8.3	☑	Rapport_Final_GEV_BFA_Version_30_08_2012.pdf **File desc:** **Date/time** 25/08/2015 09:46:11 **Size:** 1 MB
26	Improvement plan based on EVM	8.3	☑	8. Plan d'amélioration_GEV-BFA_31 Aout 2012.xlsx **File desc:** **Date/time** 25/08/2015 09:44:30 **Size:** 101 KB
27	EVM improvement plan progress report	8.3	☑	MISE EN OEUVRE DU PLAN D'AMELIORATION GEV.pdf **File desc:** **Date/time** 04/09/2015 01:34:37 **Size:** 666 KB

28	Detailed model budget for the grant for the introduction of a vaccine / operating costs	6.x,7.x.2	☑	BUDGET INTRODUCTION ET CAMPAGNE MENA 2016.xlsx **File desc:** **Date/time** 08/09/2015 04:47:35 **Size:** 89 KB
29	Risk assessment and consensus meeting report for Meningitis / Yellow Fever vaccine: (for yellow fever please include information required in the NVS guidelines on YF Risk Assessment process)	7.1	☑	EVALUATION DES RISQUES.docx **File desc:** **Date/time** 08/09/2015 10:52:00 **Size:** 11 KB
30	Plan of Action for campaigns	7.1, 7.x.4	☑	2. Annexe1_PAO_MenAfriVac 14082015.docx **File desc:** **Date/time** 02/09/2015 05:39:53 **Size:** 79 KB
	Other documents		☒	No file loaded

11. Appendices

Annex 1 - NVS Routine Support

Annex 1.1 - NVS Routine Support (meningitis A, 10 dose(s) per vial, LYOPHILISED)

Table Annex 1.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in US$

		2015
Number of vaccine doses	#	0
Number of AD syringes	#	0
Number of re-constitution syringes	#	0
Number of safety boxes	#	0
Total value to be co-financed by country ***[1]***	$	0

Table Annex 1.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$

		2015
Number of vaccine doses	#	0
Number of AD syringes	#	0
Number of re-constitution syringes	#	0
Number of safety boxes	#	0
Total value to be co-financed by Gavi	$	0

Table Annex 1.1 C: Summary table for Meningococcal A vaccine, 10 dose(s) per vial, lyophilised

ID		Data from		2015
	Number of surviving infants	Table 5.2:	#	732,675
	Vaccine Coverage	Table 5.2:	%	0
	Number of children to be vaccinated with the first dose	Table 5.2:	#	0
	Number of doses per child	Parameter	#	1
	Estimated vaccine wastage factor	Table 5.2	#	1
	Number of doses per vial	Parameter	#	10
	AD syringes required	Parameter	#	Yes
	Reconstitution syringes required	Parameter	#	Yes
	Safety boxes required	Parameter	#	No.
cc	**Country co-financing per dose**	Table 6.4.1	$	20
ca	**AD syringe price per unit**	Table Annexes 4A	$	0.448
cr	**Reconstitution syringe price per unit**	Table Annexes 4A	$	0.035
cs	**Safety box price per unit**	Table Annexes 4A	$	0.0054
fv	**Freight cost as % of vaccines value**	Table Annex 4B	%	12.00%
fd	**Freight cost as % of devices value**	Parameter	%	0

Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, lyophilised, associated injection safety material and related co-financing budget (page 1)

		Formula	2015		
			Total	Government	Gavi
A	Country co-finance	*V*	0.00%		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	0	0	0
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B X C*	0	0	0
E	Estimated vaccine wastage factor	*Table 5.2*	1		
F	Number of doses needed including wastage	*D X E*	0	0	0
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	0	0	0
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	0	0	0
J	Number of doses per vial	*immunisation parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	0	0	0
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 × 1.11*	0	0	0
N	Cost of vaccines needed	*I x * vaccine price per dose (g)*	0	0	0
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	0	0	0
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	0	0	0
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	0	0	0
U	Total country co-financing	*I x country co-financing per dose (cc)*	0		
V	Country co-financing % of Gavi supported proportion	*U / T*	0.00%		

Annex 2 - NVS Routine – Preferred Second Presentation

No NVS - routine immunisation - second preferred format requested this year

Annex 3 - NVS Preventive campaign(s)

No prevention campaign support this year

Annex 4

Table Annex 4A: Commodities Cost

Estimated prices of supply are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2015
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	MENA CONJUGATE	12.50%

Table Annex 4C: Low income - Country's minimum co-payment per dose of co-financed vaccine

Vaccine	2015
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	0.2

Table Annex 4D: Wastage rates and factors

The table below presents the waste rates for the different vaccines (routine immunisation and campaigns) for 2015.

Vaccine	dose(s) per vial	Maximum Wastage rate*		Benchmark Wastage Rate ***
		Routine	Campaign	
Yellow fever, 10 doses per vial, LYOPHILISED	10	40%	40%	
Yellow fever, 5 doses per vial, LYOPHILISED	5	10%	10%	
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	10	50%	10%	
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	10%	10%	
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	5%	5%	
Rotavirus, 2-dose schedule	1	5%	5%	
Rotavirus, 3-dose schedule	1	5%	5%	
Measles, 2nd dose, 10 dose(s) per vial, LYOPHILISED	10	40%	40%	
JE, 5 dose(s) per vial, LYOPHILISED	5	10%	10%	
HPV bivalent, 2 dose(s) per vial, LIQUID	2	10%	10%	
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5%	5%	
MR, 10 dose(s) per vial, LYOPHILISED	10	15%	15%	

Observations:

*Source: WHO recommended wastage rates

**Source: Country APRs and studies, approved by WHO, UNICEF, and the Gavi Secretariat

Note: HPV demonstration project wastage rates are the same as for the vaccine

Table Annex 4E: Vaccine maximum packed volumes

Please note that this table is used solely for reference and includes both the vaccines supported by GAVI as well as vaccines not supported.

Vaccine product	Designation	Vaccine formulation	Admin route	No. of doses in the schedule	Presentation (doses/vial, prefilled)	Packed volume vaccine (cm3/dose)	Packed volume diluents (cm3/dose)
BCG	BCG	lyophilised	ID	1	20	1,2	0,7
Diphtheria-Tetanus	DT	liquid	IM	3	10	3	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	20	2,5	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	10	3	
DTP liquid + Hib freeze-dried	DTP+Hib	liquid+lyop.	IM	3	1	45	
DTP-HepB combined	DTP-HepB	liquid	IM	3	1	9.7	
DTP-HepB combined	DTP-HepB	liquid	IM	3	2	6	
DTP-HepB combined	DTP-HepB	liquid	IM	3	10	3	
DTP liquid + Hib freeze-dried	DTP+Hib	liquid	IM	3	10	2.5	
DTP liquid + Hib freeze-dried	DTP-HepB-Hib	liquid+lyop.	IM	3	1	22	

DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid+lyop.	IM	3	2	11	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	10	4.4	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	2	13.1	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	1	19.2	
DTP-Hib combined liquid	DTP+Hib	liquid+lyop.	IM	3	10	12	
DTP-Hib combined liquid	DTP+Hib	liquid	IM	3	1	32.3	
Hepatitis B	HepB	liquid	IM	3	1	18	
Hepatitis B	HepB	liquid	IM	3	2	13	
Hepatitis B	HepB	liquid	IM	3	6	4.5	
Hepatitis B	HepB	liquid	IM	3	10	4	
Hepatitis B UniJect	HepB	liquid	IM	3	Uniject	12	
Hib freeze-dried	Hib_lyo	lyophilised	IM	3	1	13	35
Hib freeze-dried	Hib_lyo	lyophilised	IM	3	2	6	
Hib freeze-dried	Hib_lyo	lyophilised	IM	3	10	2.5	3
Hib liquid	Hib_liq	liquid	IM	3	1	15	
Hib liquid	Hib_liq	liquid	IM	3	10	2.5	
Human Papillomavirus vaccine	HPV	liquid	IM	3	1	15	
Human Papillomavirus vaccine	HPV	liquid	IM	3	2	5.7	
Japanese Encephalitis	JE_lyo	lyophilised	SC	1	5	2.5	2,9
Measles	Measles	lyophilised	SC	1	1	26.1	20
Measles	Measles	lyophilised	SC	1	2	13.1	13,1
Measles	Measles	lyophilised	SC	1	5	5.2	7
Measles	Measles	lyophilised	SC	1	10	3.5	4
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	1	26.1	26,1
Measles-Mumps-Rubella lyophilised	MMR	lyophilised	SC	1	2	13.1	13,1
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	5	5.2	7
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	10	3	4
Measles-Rubella freeze dried	RR	lyophilised	SC	1	1	26.1	26,1
Measles-Rubella freeze dried	RR	lyophilised	SC	1	2	13.1	13,1
Measles-Rubella freeze dried	RR	lyophilised	SC	1	5	5.2	7
Measles-Rubella freeze dried	RR	lyophilised	SC	1	10	2.5	4
Meningitis A conjugate	Men_A	lyophilised	IM	1	10	2.6	4
Meningitis A/C	MV_A/C	lyophilised	SC	1	10	2.5	4
Meningitis A/C	MV_A/C	lyophilised	SC	1	50	1.5	3
Meningitis W135	MV_W135	lyophilised	SC	1	10	2.5	4
Meningococcal A/C/W/	MV_A/C/W/Y	lyophilised	SC	1	50	1.5	3

Meningococcal A/C/W/Y	MV_A/C/W/Y	lyophilised	SC	1	10	2.5	4
Monovalent OPV-1	mOPV1	liquid	Oral		20	1.5	
Monovalent OPV-3	mOPV3	liquid	Oral		20	1.5	
Pneumo. conjugate vaccine 10-valent	PCV-10	liquid	IM	3	1	11.5	
Pneumo. conjugate vaccine 10-valent	PCV-10	liquid	IM	3	2	4.8	
Pneumo. conjugate vaccine 13-valent	PCV-13	liquid	IM	3	1	12	
Polio	OPV	liquid	Oral	4	10	2	
Polio	OPV	liquid	Oral	4	20	1	
Polio inactivated	IPV	liquid	IM	3	PFS	107.4	
Polio inactivated	IPV	liquid	IM	3	10	2.5	
Polio inactivated	IPV	liquid	IM	3	1	15.7	
Rota vaccine	Rota_liq	liquid	Oral	2	1	17.1	
Rota vaccine	Rota_liq	liquid	Oral	3	1	45.9	
Tetanus Toxoid	TT	liquid	IM	2	10	3	
Tetanus Toxoid	TT	liquid	IM	2	20	2.5	
Tetanus Toxoid UniJect	TT	liquid	IM	2	Unijject	12	
Tetanus-Diphtheria	Td	liquid	IM	2	10	3	
Yellow fever	YF	lyophilised	SC	1	5	6.5	7
Yellow fever	YF	lyophilised	SC	1	10	2.5	3
Yellow fever	YF	lyophilised	SC	1	20	1.5	2
Yellow fever	YF	lyophilised	SC	1	50	0.7	1

12. Banking form

In accordance with the decision on financial support made by Gavi, the Government of Burkina Faso hereby requests that a payment be made via electronic bank transfer as detailed below:

Name of Institution (Account Holder):			
Address:			
City Country:			
Telephone no.:		**Fax no.:**	
	Currency of the bank account:		
For credit to:			
Bank account's title:			
Bank account no.:			
Bank's name:			

Is the bank account exclusively to be used by this program?

By who is the account audited?

Signature of Government's authorizing official

		Seal
Name:		
Title:		
Signature		
Dated:		

FINANCIAL INSTITUTION		**CORRESPONDENT BANK (In the United States)**	
Bank's name:			
Branch Name:			
Address:			
City Country:			
Swift Code:			
Sort Code:			
ABA No.:			
Telephone No.:			
FAX No.:			

I certify that the account No. is held by at this banking institution

The account must be signed jointly by at least (number of signatories) of the following authorized signatories:

1		
	Name:	
	Title:	
2		
	Name:	
	Title:	
3		
	Name:	
	Title:	

Name of bank's authorizing official
Signature
Dated:
Seal: