MINISTRY OF HEALTH
BURKINA FASO

Unity - Progress - Justice

APPLICATION FOR HEALTH SYSTEM STRENGTHENING RELATED TO IMMUNISATION (2017-2021)

September 2016

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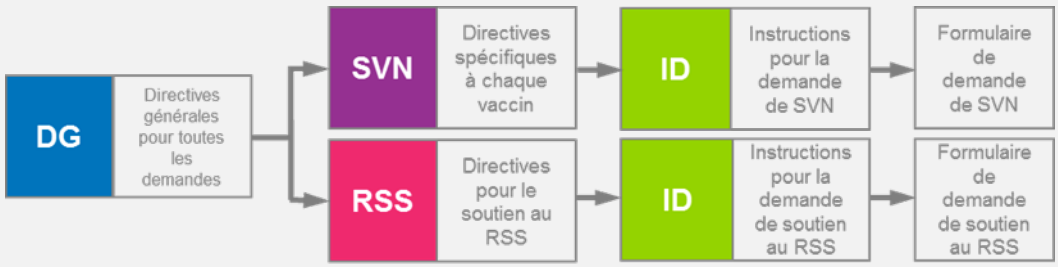
Application Form
Health System Strengthening Support (HSS) in 2016

Deadlines for submission of application:
15 January 2016
01 May 2016
09 September 2016

Document date: October 2015
(This document replaces all previous versions)

Application documents for 2016:

Countries applying for all types of Gavi support in 2016 are advised to refer to the following documents in the order presented below:



Application Form:	**Purpose of this document:** This application form must be completed in order to apply for Gavi's HSS Support. Applicants are required to read the HSS Application Instructions prior to completing this application form and are advised to refer to these instructions whilst completing the application form. Applicants should first read the General Guidelines for all types of support as well as the HSS Guidelines before this document. The application form, along with any attachments, must be submitted in English, French, Portuguese, Spanish, or Russian.

Weblinks and contact information:

All application documents are available on the Gavi Apply for Support web page: www.gavi.org/support/apply For any questions regarding the application guidelines please contact applications@gavi.org or your Gavi Senior Country Manager (SCM).

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PART A: SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

1. Applicant information		
Total funding requested from Gavi (US $)	*This should correspond exactly to the budget requested in Question 17 (detailed budget): US$ 11.76 million*	
Does your country have a finalised and approved National Health Sector Plan?	Yes [X]	No [ ]
	*Indicate the**end of the year** for the NHDP: 2020* ***Provide Mandatory Attachment #8: NHDP***	
Does your country have a finalised and approved comprehensive Multi-Year Plan (cMYP)?	Yes [x]	No [ ]
	Indicate the end of the year for the cMYP: 2020 ***Provide Mandatory Attachment #11: cMYP***	
Proposed HSS grant start date:	*Indicate the month and year of the planned start date of the grant..* 1st July 2017	
Proposed HSS grant end date:	*Indicate the month and year of the planned end date of the grant.* 31 December 2021	
Joint appraisal planning:	*Indicate when in the year the joint appraisal will be conducted, and which HLRP meeting the joint appraisal report will be submitted to.* *July 2017* *Panel: Gavi Secretariat, WHO and Unicef*	

2. Application development process (Maximum 2 pages)

Provide an overview of the collaborative and participatory application development process.
*Include the **following Mandatory Attachments:***

No. 4: *Minutes of HSCC meeting, at which the HSS application was endorsed;*

No. 5: *Minutes of the last 3 HSCC meetings; and*

No. 5: *TOR of HSCC*

In order to submit the new application on-time, the submission committee comprising representatives of national offices[1] of the Ministry of Health, civil society organisations and the private sector participating in the field of health was reorganised with the support of the technical and financial partners (TFP). The

[1] General directorate of sectoral statistics and studies, General directorate of pharmacies, medication and laboratories, General Directorate of health, Directorate of prevention through immunisation, Directorate of administration and finance.

proposal's development process was led by the Ministry of Health's Directorate of Research and Sectoral Statistics (DGESS), and the Directorate for Coordination and Planning of Health Programmes Monitoring and Evaluation (DTCP). Technical assistance was officially requested from the TFPs to support the committee. This application was favourably received, resulting in the participation of WHO and Unicef in all stages of the document preparation process.
Civil Society was represented by 5 members coming from the CSOs of the national platform of NGOs and immunisation and support associations in Burkina Faso (PNOSV-BF). These CSOs are:

- Action pour l'enfance et la santé au Burkina Faso (AES/Burkina) ;
- Association Songui Manégré/aide au développement endogène (ASMADE) ;
- Fondation pour le développement communautaire/Burkina Faso (FDC/BF) ;
- Réseau africain jeunesse santé et développement au Burkina Faso (RAJS/BF);
- Réseau accès aux médicaments essentiels (RAME).

The role of civil society consisted of providing technical support in the context of the preparation of the application, implementation by the Ministry, in particular ensuring the consideration of immunisation application creation activities and EPI governance. Implementation of the "Civil Society-Government" dialogue framework in the context of Gavi HSS was also a key point of the contribution by civil society to the development of this request.

The private sector, represented by the Association des cabinets de soins privés [Association of private health care facilities] also participated in all stages of the process.

Before the start of the application development process, a Gavi HSS 2 review was conducted by SERSAP in place of an assessment, by mutual agreement with the Gavi Secretariat. The results were presented to the members of the drafting committee and the resource personnel for operation for the development of this application to be submitted to Gavi.
In order to file the application by 9 September 2016, a working schedule was proposed. The development work started with an initial workshop held 11-23 July 2016. Upon completion of that initial workshop, a small committee met to ensure the consistency of the document before the working draft was sent to other members of the committee for revisions. Similarly, partners such as WHO, Unicef and the European Union participated with the drafting committee through representatives in certain of the development workshops and through email contact to amend the draft at all stages.
A 2nd workshop, held 1-13 August 2016, allowed the revisions to be considered and produced an initial draft that was then submitted to resource persons and the TFPs for review. This draft was also revised during the joint assessment held from 8-12 August 2016.
It must be noted that the breakdown of activities resulting from bottlenecks took into consideration what was planned in the context of the support from other financial partners.

A 3rd workshop was held from 22-27 August 2016 in Ouagadougou, during which the comments from resource persons were incorporated.

To make the process as participative and inclusive as possible, the draft document was presented to the officials from the central and peripheral structures of the Ministry of Health, and to the technical and financial partners during a 4th workshop held on 30 August 2016 in Ouagadougou. The draft application was sent to the 13 Regional Health Directors (DRS) in the country 5 days before the validation workshop was held. This 5-day period allowed each DRS to review said draft with the Health District Executive Teams (ECDs).
Changes submitted were incorporated during a 5th workshop that was held from 31 August to 2 September 2016 by a select committee.

In addition, the ICC reviewed the application at its 4 July 2016 and 29 September 2016 sessions. During said sessions, the revisions by members of the ICC were collected in order to enhance the document.

The draft of the application was then submitted on 5 September 2016 to the members of the subject-specific commissions of the NHDP Oversight Committee for approval.

The resubmission, as finalised, was approved by the Ministers of Health and Finance before it was submitted to the Gavi Secretariat.

After this submission, a preliminary review was conducted by WHO headquarters, the revisions from which were incorporated by the drafting committee from 3 to 12 October 2016.

With regard to technical assistance received from the technical and financial partners, in the process of development of the Gavi application, the team that was set up for development received technical assistance, primarily from WHO (WHO-Country and WHO Inter-country based in Burkina Faso) and from Unicef:
- Development phase: These TFPs provided technical support based on their expertise/knowledge of the domains/procedures for intervention by the various TFPs and their mastery of health development guidelines and issues. Similarly, their cumulative experience in techniques (new tools) for developing applications were very helpful in the preparation of the application.
- Internal validation phases: workshops were held with the subject-specific oversight (HSCC, regional committees, subject-specific committees) and the contribution of the TFPs was a determining factor throughout the amendments of format and substance regarding the prioritisation of domains, the establishment of objectives, definition of activities and budgeting. Their contribution allowed preference to be given to significant actions to which the Gavi application should be dedicated.
Additionally, interactions developed through mail exchanges to enhance the application.

3. 3. Signatures

3a. Government endorsement

Include Minister of Health and Minister of Finance endorsement of the HSS proposal – ***Mandatory Attachment No. 2.***

We, the undersigned, affirm that the objectives and activities of the Gavi proposal are fully aligned with the national health strategic plan (or equivalent), and that the funds for implementing all activities, including domestic funds and any needed vaccine co-financing, will be included in the annual budget of the Ministry of Health.

Minister of Health	**Minister of the Economy, Finance and Development**
Name: Dr Smaïla OUEDRAOGO	Name: Hadizatou Rosine COULIBALY/ SORI
Signature:	Signature:
Date:	Date:

3b. Health Sector Coordinating Committee (HSCC) endorsement

*Include HSCC official endorsement of the HSS proposal –****Mandatory Attachment #3***

Include a signature of each committee member in attendance and date.

Mandatory Attachment No. 3**: HSCC Endorsement of HSS Proposal**

We the undersigned members of the HSCC, or equivalent committee, met on 05 September 2016 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.

Please list all	Title/Organisation	Name	Sign below to confirm:

HSCC members			Attendance at the meeting where the proposal was endorsed	Endorsement of the minutes where the proposal was discussed
Chair				
Secretary				
MOH members				
Development partners				
CSO members				
WHO				
UNICEF				
Other				

4. Executive Summary (Maximum 2 pages)

Provide an executive summary of the application.

Burkina Faso is submitting an application for US$ 11.76 million over a 5-year period (1 July 2017 – 31 December 2021). To this end, a review of the current status was conducted and it showed the following primary bottlenecks:

Regarding leadership and governance: (i) operational insufficiency of the EPI coordination bodies and support structures for the implementation of the grant;(ii) poor involvement of civil society, the private sector and the community sphere in immunisation activities;(iii) insufficient planning, monitoring and assessment of Gavi HSS activities.

With regard to the delivery of services: (i) insufficient integrated and specific EPI supervisions; (ii) insufficient vaccine coverage in certain health districts; (iii) insufficient implementation of immunisation strategies; (iv) insufficient monitoring of immunisation data.

Regarding personnel and human resources: (i) insufficient instructional material in the area of immunisation for public and private training schools;(ii) insufficient skills for implementation of immunisation and communication activities.

With regard to health promotion and fighting disease: (i) insufficient implementation of communication strategies; and (ii) poor mobilisation of people in support of immunisation activities.

With regard to infrastructure, equipment and health care products: (i) insufficient vaccine management; (ii) insufficient storage capacity; (iii) outdated condition of certain cold rooms at the central and regional levels; (iv) insufficient supervision vehicles at the central, regional and district levels; (v) insufficient logistics vehicles for health care facilities;(vi) insufficient high-capacity computers necessary for operational use of the vaccine management tool (DVD/MT) at all levels; (vii) insufficient cold room maintenance at the central level and in certain regional departments; (viii) insufficient cold rooms at the central and local levels to house them;(ix) insufficient/lack of refrigerators in CSPS/CM.

With regard to the health information system: (i) the poor quality of data, including immunisation data, due to the insufficient skills of EPI supervisors, DRS and Health Districts in the use of the Endos-BF database; poor availability of media for data collection, including immunisation data; insufficient self-assessment of data quality (DQS) for the EPI; insufficient skills of personnel responsible for data collection and management; non-availability of a sufficient connection to allow data entry into the Endos-BF database; insufficiency in the collection and capitalisation of data for immunisation activities in the private sector, community sphere and among NGOs/Associations; insufficient operation of regional immunisation data validation frameworks; insufficient regular analysis of vaccine stock management indicators; insufficiency in the regular analysis of performance indicators at the district level; insufficiency in regular feedback; insufficiency and/or absence of monitoring data validation.

With regard to health funding: insufficient harmonisation of funding contributions by partners at the Ministry of Health level.

In order to remove these bottlenecks and in order to contribute to the improvement of the health of the general population and that of children in particular, a primary objective was identified: to contribute to the strengthening of capacities of the health system to attain the EPI goals through the end of 2021. The specific objectives of the application, of which there are 4, are aligned with the objectives of the 2016-2020 cMYP and the 2011-2020 NHDP. These objectives were targeted in response to the primary bottlenecks that were observed, and they are intended to: (i) strengthen coordination, monitoring and assessment of the health system from 2017 through 2020 (ii) improve the delivery of immunisation services by increasing the percentage of districts with a 100% fully immunised child rate through 2020 from 55.5% to 90%; (iii) increase the routine immunisation data consistency index from 93.6% to 97% through the end of 2020; (iv) strengthen the management of the supply chain for vaccines, consumables and logistics at all levels. Civil society organisations were included and involved in the implementation of activities relative to these 4 objectives, and they represent 2.8% of the total HSS budget..
In order to attain these objectives, forty-eight (48) activities were planned and broken down by objective, as follows: Objective 1: 21 activities representing 16.7% of the budget; Objective 2: 13 activities representing 42.3% of the budget; Objective 3: 05 activities representing 12.7% of the budget; Objective 4: 9 activities representing 28.2% of the budget;

These activities will target 28 selected health districts on a priority basis based on the fully immunised child performance criteria (<100%), which were supplemented by the 7 new districts which, based on their status, warrant strengthening of their capacity. The provision of immunisation services in these districts, as with the other districts in the country, is based on equity pursuant to the values of the national health policy, although the country has not prepared an immunisation equity plan. Furthermore, statistical analysis shows that regardless of the period and immunisation in question, the girl/boy coverage ratios are very close to equal: 0.99 for BCG and 1.08 for complete vaccine coverage. The discrepancies are not significant.
According to the 2009 in-depth assessment of the EPI, the reasons for non-immunisation are primarily linked to insufficiencies with regard to knowledge about the importance of immunisation (21%); poor knowledge of the immunisation schedule (38%); unfamiliarity with the need to return for subsequent doses (16%); being unaware of the place and time of the session (12%); absence of the vaccinating agent and fear of side effects (13%). Similarly, reports from DPV supervisions have shown that the ongoing presence of non-immunised children is linked to poor coverage of particular areas (disadvantaged zones, markets, gold panning sites, cultural hamlets, border zones, etc.) and insufficient searching for children who miss immunisation sessions. In addition, these reports note the poor skills of health care agents with regard to the EPI, based on their constant mobility and poor implementation of support (supervision, etc.), poor vaccine storage capacity at all levels due to the introduction of new vaccines; insufficient Cold Chain equipment due to certain refrigerated equipment being outdated, interruption of the cold chain due to electrical generating groups not being available to cold room links between the DRS and the districts, insufficient implementation of advanced strategies and supervision due to insufficient 2- and 4-wheel vehicle logistics and insufficient implementation of communication activities in support of immunisation due to the poor funding for communication activities and insufficient involvement by external actors. This reasoning shows that the causes for non-immunisation are linked to programme management and not to inequality in the delivery of immunisation services. It is in this regard that the relevant actions have been addressed in the framework of the application.

The procedures for implementing activities will be incorporated into funding mechanisms for the annual action plans for the structures of the Health Ministry. For civil society activities, all the funds will be paid into a SPONG account via the HDSP, which will conduct the corresponding audit. These activities have as their primary implementation body the Ministry of Health via its operational bodies, along with the participation of Civil Society Organisations (CSOs) and the private healthcare subsector.
Implementation methods, financial management, coordination and strategic monitoring of the proposal will be integrated into existing mechanisms (tools, instances, methodology, and frameworks for monitoring health plans and programs) at all levels of the health system. The coordination mechanism will be the same as the one from the 2011-2020 NHDP.

Significant internal and external risks that could have a negative impact on the implementation of the

proposal have been identified, and harm reduction strategies have been proposed.

5. Acronyms

Provide a full list of all acronyms used in this application.

Acronym	Acronym meaning
ACV	*: Contracting and verification agency*
AES/Burkina	*: Action pour l'enfance et la santé au Burkina Faso;*
AFD	*: Agence Française de Développement (French Development Agency)*
WHO	*: Agency for Preventive Medicine*
ARCOP	*: Autorité de régulation de la commande publique*
ARCSP	*: Association des responsables des cabinets de soins privés*
ASBC	*: Community-based health agent*
ASMADE	*: Association Songui Manégré/aide au développement endogène*
CBWAS	*: Central Bank of West African States*
IC	*: Bacillus Calmette-Guérin*
CASEM	*: Board of Directors of the Ministerial Sector*
ICC	*: Interagency Coordinating Committee*
HSCC	*: Health Sector Coordination Committee*
CHR	*: Centre hospitalier régional [Regional Hospital]*
CHU	*: University Hospital Centre*
CISSE	*: Centre d'information sanitaire et de surveillance épidémiologique [Health Information and Epidemiological Surveillance Centre]*
CM	*: Centre médical [neighbourhood Medical Centre]*
CMA	*: Centre médical avec antenne chirurgicale [neighbourhood Medical Centre with Surgical Facilities]*
MC	*: Management Committee*
PNC	*: Prenatal consultation*
NHDP/RMC	*: Regional Monitoring Committee of the NHDP*
NHDP/MC	*: Monitoring Committee of the NHDP*
CSD	*: Conseil de Santé de District [District Health Council]*
CSPS	*: Centre de santé et de promotion sociale [Health and Social Promotion Centre]*
CMA	*: Centre médical avec antenne chirurgicale [Neighborhood Medical Centre with Surgical Facilities]*
CESAG	*: African centre for advanced management studies*
CM	*: Neighbourhood medical centres*
NHDP/RMC	*: Regional Monitoring Committee of the NHDP*
CSD	*: Sectoral dialogue framework for health and nutrition*
CSD	*: District Health Council*
TAC/EPI	*: Technical Advisory Committee to the EPI*
CTRS	*: Regional Technical Health Committees*
DAF	*: Financial Affairs Directorate*
DGESS	*: General Directorate of Sectoral Statistics and Research*
DGPML	*: General Directorate of Pharmacies, Medication and Laboratories*
DGS:	*: Directorate of Health*
DHIS	*: District Health Information Software*
DCD:	*: Directorate of Disease Control*
DPV	*: Directorate of Prevention through Immunisation*
DRS:	*: Data Quality Self Assessment (Auto-evaluation of data quality)*
RHD	*: Regional Directorate of Health*
DSEC	*: Directorate of Monitoring, Assessment and Capitalisation*
HD	*: Health District*

DTC2	*: First dose of Diphtheria, Tetanus, and Pertussis vaccine*
DVD-MT	*: Data vaccine district management tool*
DMT	*: District Health Management Team*
EMC-MDS	*: Multi-centre Study*
ENDOS-BF	*: National Health Data Warehouse - Burkina Faso*
FASPB	*: Federation of private health associations of Burkina Faso*
RBF	*: Results-Based Financing*
FDC/BF	*: Foundation for Community Development/Burkina Faso*
MT	*: Healthcare facility*
DH	*: District Hospital*
Gavi	*: Global Alliance for Vaccines and Immunisation*
FM	*: Financial management*
HIPC	*: Viral Hepatitis B*
HiB	*: Haemophilus Influenzae B*
PSDSS	*: Post Chief Nurse*
IDE :	*: State Registered Nurse with Degree*
HIV	*: Information education communication*
QWI	*: Quick Win Intervention*
INSD	*: Institut national de la statistique et de la démographie (National Institute of Statistics and Development)*
ARI	*: Acute Respiratory Infection*
HSTI	*: Health Services Technical Inspectorate*
LQAS	*: Lot quality assurance sampling*
AEFI	*: Adverse Event Following Immunisation*
MLM/EPI	*: Mid-level Management Course on the EPI*
MINEFID	*: Ministry of the Economy, Finance and Development*
MEV	*: Vaccine Preventable Disease*
OBCE	*: Community-Based Implementing Organisation*
MDG	*: Millennium Development Goal*
WHO	*: World Health Organisation*
NGO	*: Non-governmental Organisation*
NGO/RENCAP	*: Non-governmental Organisation for Capacity Building*
CSO	*: Civil Society Organisation*
HDSP	*: Health Development Support Programme*
EPI	*: Expanded Programme on Immunisation*
AFP	*: Acute Flaccid Paralysis*
MPA	*: Minimum Package of Activities*
NHDP	*: National Health Services Development Plan*
NHP	*: National Health Policy*
PNOSV-BF	*: National Platform of NGOs and Immunisation and Vaccination Support Associations of Burkina Faso*
cMYP	*: Comprehensive Multi-Year Plan*
TFP	*: Technical and Financial Partner*
VVM:	*: Vaccine Vial Monitor*
RAJS/BF	*: African Youth Health and Development Network in Burkina Faso*
RAME	*: Network access to essential medications*
ORS	*: Human Resources for Health*
RMAT	*: Theoretical average action radius*
HSS	*: Health System Strengthening*
SARA	*: Survey on the availability of services and operational capacity*
SBC	*: Community-Based Service*
CBS	*: Community-Based Surveillance*
SERSAP	*: Public Health studies and research*
SLM	*: Department of Disease Control*
AIDS	*: Acquired Immune Deficiency Syndrome*
NSMI	*: National Health Information System*
SPONG	*: Permanent Secretariat of NGOs*
CRS:	*: Congenital rubella syndrome*

TLOH	*: Official weekly telegram*
NNT	*: Neonatal Tetanus*
TPS	*: Traditional Health Practitioner*
MU-HDSP	*: HDSP Management Unit*
UNFPA	*: United Nations Population Fund*
UNICEF	*: United Nations Children's Fund*
YFV	*: YF vaccine*
MV	*: Measles vaccine*
TTV2 and higher	*: Tetanus Toxoid Vaccine (2nd and higher dose)*
HIV	*: Human Immunodeficiency Virus*
IPV	*: Inactivated Polio Vaccine*

PART B: BACKGROUND

6. Description of the National Health Sector (Maximum 1 page)

*Provide mandatory Attachment **No. 8**: NHDP or or equivalent and reference which sections describe the national health sector. If no existing approved national document describes the national health sector, provide a concise overview of the national health sector.*

Burkina Faso's health system is organised as follows:
On the administrative level, it is structured into 3 levels:

- Peripheral: 70 Healthcare Districts (HD), which are operational and are the entities charged with planning and implementing healthcare programmes, including those to fight vaccine-preventable diseases;

- intermediate: 13 Regional health directors (DRS) that implement the NHDP at the regional level. They have a Unit to fight disease (SLM), which coordinates the fight against diseases, including those that are disease-avoidable.

- central: under the authority of the Office and the General Secretariat; it provides guidelines and coordination of the implementation of the NHP and the NHDP. The General directorate for health implements programmes to fight disease, including those for prevention through immunisation.

At the level of the organisation of health care, by health care facilities, is distributed in to the public, private and traditional subsectors.
The public sub-sector consists of:

- the 1st level comprises primarily: i) 1698 Healthcare and social promotion centres (CSPS) and 43 Medical centres (CM) that comprise the 1et line. They offer a minimum package of activities (MPA) for prevention, promotion, treatment and rehabilitation, including immunisation; (ii) 47 Medical centres with surgical facilities (CMA) or District Hospitals (HD) comprise the 2nd line which offers the supplemental package of activities.

- The 2nd level comprises 9 regional hospital centres (CHR), referral facilities for CMAs or Health Districts, training and research;

- The 3rd level comprises 4 university hospital centres (CHU), which are referral facilities for the CHRs, research and training for healthcare professionals.

The private healthcare sub-sector included 395 private healthcare facilities, 193 offices and 524 pharmaceutical depots in 2015.
The traditional healthcare sub-sector comprises traditional health practitioners (TPS), organised in to village-based cells and departmental, provincial, regional and national associations. They are associates at the community level for promotion of immunisation.
At the community level, there are 17,790 community-based health agents (ASBC) and 629 associations that offer community-based healthcare services in connection with basic healthcare

facilities and the Health Districts. An approach for contracting with NGOs and associations was developed by the Ministry of Health via the Health Development Support Program (HDSP) to strengthen "Quick impact interventions" (IGR) in healthcare, including immunisation interventions.

7. National Health Sector Plan (NHSP) and relationship with cMYP (Maximum 2 pages)

Describe the relationship of the cMYP to the national health strategy.

*Provide: **Mandatory Attachment No. 8**: NHDP and **No. 11: cMYP**; and if available: **Attachment No. 18**: Joint assessment of National Health Strategy (JANS); and **Attachment No. 19**: Response to the JANS.*

❖ **The relationship between the cMYP and the HHDP is established via the following points**

- The 2016-2020 cMYP in its design and implementation schedule is integrated into the 2011-2020 NHDP. Its coverage period lines up with the second half of the 2011-2020 NHDP;
- The cMYP is the specific breakdown of the 2011-2020 NHDP for the development of immunisation activities. These activities were implemented by the Directorate of Prevention through Vaccines (DPV), which is one of the technical directorates of the General Directorate of Health It participates in the implementation of national health policy, in its immunisation section, via the Expanded Programme on Immunisation (EPI).
- The EPI is one of the priority programmes of the Ministry of Health, the interventions of which via the cMYP contribute to attaining the overall objective of the NHDP which is "to contribute to improving the health condition of populations";
- The cMYP is based on the guidelines of the NHDP in particular guideline No. 4 relative to health promotion and fighting disease. One of the axes of intervention for this guideline is to strengthen the fight against communicable diseases and the selected priority actions include: (i) strengthening universal immunisation; (ii) implementation of specific programs targeting the eradication, elimination and control of communicable diseases;
- The cMYP, in its development, prepares the components resulting from the 2011-2020 NHDP intervention axes, in particular delivery of service; case surveillance and reporting; communication; human resources management; programme management; vaccines, cold chain and logistics and funding of the EPI;
- the mechanism for follow-up and assessment of the NHDP includes that of the cMYP via the following entities: (i) the sectoral health and nutrition dialogue (CSD) at the central level; (ii) the regional NHDP monitoring committee (CRS/NHDP) at the intermediate level; (iii) the Health District Council (CSD) at the peripheral level;
- The information system used by the cMYP is the national health information system developed in the framework of the NHDP implementation. The data collected were used to inform the NHDP performance monitoring indicators in the field of immunisation. These indicators are: the TT2 coverage rate among pregnant women, the MV coverage rate, the Pentavalent3 coverage rate, the percentage of districts having a Pentavalent3 coverage rate greater than or equal to 80%
- the frameworks for monitoring the NHDP and the cMYP were presided over by the Minister of Health;
- one of the cMYP strategies is "research, development and innovations". This is contained in Guideline No. 7 of the NHDP which targets promotion of health research. This strategy of the

cMYP is structured around the following priority actions: i) conducting socio-demographic studies on immunisation activities; ii) collaborating with research centres; and iii) participating in scientific days;

- Funding of the 2011-2020 NHDP includes that of the cMYP which represents a significant aspect with the contribution from the Government, the technical and financial partners, the private sector (NGOs/Associations, Companies, the support of communities);

❖ **Joint Assessment of National Health Strategy (JANS)**

- **Report of Joint Assessment of National Health Strategy (JANS);**

It took place from 1-19 August 2016, with technical and financial support from WHO, which mobilised a Senior Consultant for this purpose. A work programme was established and coordinated around the training of all healthcare system participants, including the Technical and Financial Partners, interviews and field visits in 2 DRS. The preliminary results were released on 19 August 2016.

- **Involvement of the Gavi Alliance in the process**

Training and meetings with the development partners (bi- and multi-lateral cooperation agencies) were organised according to a schedule that was agreed upon with the latter. WHO and Unicef, acting on behalf of the Gavi Alliance and which are preferred partners of the healthcare system, were full participants in this assessment.

- **Results of the JANS assessment**

The assessment revealed the existence of a functional dialogue device and even the technical level (6 subject-specific oversight committees of the 2011-2020 NHDP), at the political level with the Government leadership. The technical and financial partner representatives are participants in the subject-specific committees, as well as representatives of the private sector and civil society. There are frameworks for dialogue and coordination with the stakeholders at the regional and provincial levels. The technical teams from the Regional Health Directorates and the Healthcare Districts prepare the operational plans, in conjunction with other actors such as the technical and financial partners and the civil society organisations which are present in the field.

8. Monitoring and Evaluation Plan for the National Health Plan (Maximum 2 pages)

Provide background information on the country M&E arrangements.

The monitoring and assessment of the 2011-2020 NHDP as specified in the NHDP national monitoring plan includes the institutional framework and the monitoring-assessment mechanism.

The institutional framework includes:

i) The National Monitoring Committee of the NHDP which serves as a framework for sectoral dialogue for all the participants in the healthcare and nutrition sector; the latter provides semi-annual and annual monitoring of sector performance. WHO and Unicef, acting on behalf of the Gavi Alliance, are preferred partners of the healthcare system. They participate in the same regard as all development partners in sectoral dialogues through the 6 subject-specific NHDP oversight committees.

ii) At the intermediate and peripheral levels, monitoring is provided by the CRS/NHDP and the CSD, respectively.

In addition to these frameworks for NHDP oversight, the EPI technical support committee and the Interagency Coordinating Committee (ICC) are specific frameworks that oversee immunisation activities that meet monthly and quarterly, respectively.

The monitoring and assessment mechanism of the NHDP is implemented via the meetings of the oversight committees at various (national and regional) levels, joint oversight visits, periodic assessments, sectoral mid-point and annual reviews and surveys. The mid-point and annual reviews of the healthcare sector that bring together the healthcare system actors is the broadest oversight instance and it is the most representative of the NHDP. They review performance levels and identify

bottlenecks that endanger the attainment of the established objectives and they propose solutions. The performance framework defined in the NHDP oversight-assessment plan includes a list of 48 indicators, with the annual targets to be attained.

8.1- Monitoring and Assessment Procedures

The monitoring and assessment system put in place in the framework for monitoring the 2011-2020 NHDP, is supplied primarily by the health data collected and processed by the national health information system (NHIS) and the National Institute for Statistics and Demographics (INSD). The selected indicators are reported regularly and periodically monitored.

The indicators of results with regard to immunisation and indicators of product/intermediary result are thus taken into consideration in the context of the performance of this application and they will also be reported by the National Health Information System. They were analysed in function of the base level (2015), their progression in relation to the objectives and targets established to be attained during the four year implementation of the proposal. Pursuant to the monitoring-assessment device put in place, a mid-point assessment is planned and a final assessment of the NHDP in the context of a participatory approach.
The monitoring system in place also takes into account the surveillance of infectious vaccine-preventable diseases, which requires strengthening in the context of this proposal, in order to improve data processing and analysis that are transmitted via Official Weekly Telegrams (TLOH). This surveillance allows unusual phenomena that are observed over time at healthcare facilities to be identified and the appropriate corresponding measures to be taken. The indicators that are defined at this level are essentially the TLOH's rate of timeliness and completeness.
The performance framework is lastly a control panel for monitoring indicators for the healthcare system participants that provides: i) the level of immunisation of the target populations; ii) the operational capacities and correct operation of management structures; iii) the quality of data generated.

For the preparation of the monitoring report for the proposal, the monitoring documents used are: national administrative data and survey reports.
The surveys on immunisation are carried out via the in-depth review of the EPI that takes place every 5 years (the last took place in 2014). Other surveys are carried out based on the pace with which new vaccines are introduced and mass campaigns are implemented.

8.2- Strengthening of the monitoring and evaluation system

Monitoring and evaluation of the implementation of the new Gavi proposal will be taken into consideration in the monitoring and evaluation process of the 2011-2020 NHDP. To this end, cooperation and dialogue frameworks put into place at all levels of the healthcare system to assess the performance of NHDP implementation will be included in the monitoring of this proposal. One of the six subject-specific specialised committees based on the strategic guidelines of the 2011-2020 NHDP is responsible for dealing with matters related to the delivery of healthcare services, including immunisation. It prepares reports that are part of the sectoral review taking into account the performance of immunisation activities.
According to the various corresponding levels, the following activities were carried out in the context of strengthening of the monitoring and assessment system for this proposal:

- **Community level**

The monitoring and assessment of activities planned by healthcare facilities is carried out via monitoring of action plans. It is organised by the Health and Social Promotion Centre, in collaboration with the management committee and with the support of the District Supervisory Team (ECD). Monitoring allows bottlenecks in the performance of activities, including those related to immunisation, to be identified and resolved.

- **Regional and healthcare district level:**

With the implementation of the Burkina Faso healthcare data warehouse (Endos-BF), the data from healthcare facilities are entered by the District Executive Teams and those of the implementing grass roots organisations (OBCE) were entered by the capacity strengthening NGOs (NGO/Rencap). These

data were processed and analysed via performance reports in the context of monitoring at the CRS/NHDP level. This committee is chaired by the Governor of the region with participation of the representatives of the decentralised government services, municipalities, civil society and the technical and financial partners (TFP). In order to ensure better quality of data entered into Endos-BF, validation and standardisation workshops were organized respectively at the district then the regional and national levels.

- **National level**

The Directorate of Forecasting and Operational Planning (DGESS) coordinates the preparation of planning guidelines for all structures of the Ministry of Health. They prepare their annual action plans that take immunisation or immunisation support activities into consideration. The Directorate of Forecasting and Operational Planning (DGESS) coordinates the monitoring of the implementation of HSS activities funded by Gavi in collaboration with the Health Development Support Programme (HDSP) and the DGS via the DPV. Additionally, the monitoring process for the proposal is steered by the monitoring committee established in February 2014 to ensure among other items quarterly monitoring of the implementation of activities funded by Gavi. Semi-annual monitoring visits were organised at the intermediate and peripheral levels and external mid-point and final assessments of the proposal were carried out.
The consideration of recommendations contributes to improving the implementation of actions scheduled in the NHDP and more specifically those scheduled in the Gavi proposal.
In the context of performance improvement, the DGESS prepares a semi-annual analytical summary report of the indicators known as the progress report based on data entered by districts, hospitals and Regional Health Districts is prepared for the monitoring instances. Since 2014, determination of the parameters of this monitoring tool was carried out in Endos in order to ensure quick availability of this report and good data quality. However a review of the framework and enhancement of parameter settings are still necessary in order to accurately consider strengths, weaknesses, and difficulties encountered by the various structures, as well as the specified solutions.
The operational implementation of all actions in the Gavi proposal will also require monitoring activities, supervisions, controls, information collection, assessments/surveys at all levels.

- **Technical support and upgrading skills**

In the context of monitoring and assessment, it is necessary to continue to strengthen skills at all levels in monitoring/assessment and quality control of data and to ensure technical support for the actors in the field and in the area of proposal assessments. To this end, the contribution of the Technical and Financial Partners, as well as the cooperation of civil society, the private sector and community representatives are indispensable.

*Provide **Mandatory Attachment No. 9**: National M&E Plan (for the health sector/ strategy**),** as well as any sub-national plans, as relevant. If this does not exist, explain how the National Health Plan is currently monitored and provide a timeline for developing an M&E Plan.*

*If available, provide **Attachment No. 16**: Data Quality Assessment (DQA) report and **Attachment No. 17:** Data quality improvement plan*

Pooled fund applicants are required to *attach the National M&E Plan and any documentation on the joint review process, including terms of reference, schedule etc.*

9. Alignment with existing results based financing (RBF) programmes (where relevant) (Maximum 1 page)

Indicate whether your country will align HSS support with existing results based financing (RBF) programmes.

*If available, provide **Attachment No. 30**: Concept Note/ Programme design of relevant RBF programme, including Results Framework and Budget.*

Burkina Faso receives funding from World Bank for implementation of the results based funding (RBF) strategy for all first- and second-level healthcare facilities in 15 healthcare districts in six

regions and in four Regional Hospital Centres. The quality and quantity indicators procured by RBF in Burkina Faso include indicators related to immunisation. At present, this is a pilot phase that started in December 2014; it includes an assessment of impact that may place health officials regarding the capacity of the strategy to improve the quantity and quality of healthcare services offered to people for possible scaling up. In the interim, in the context of this proposal, the country does not anticipate aligning Gavi HSS support with the current RBF program in progress due to the fact that the approach is in its pilot phase.

Assessment of the current project's impact on healthcare facilities covered by RBF will allow a decision on whether or not to scale up the strategy and consequently, the alignment of the various RBF funding sources, after 2017.

PART C: DETAILS OF THE APPLICATION

10. Health System Bottlenecks to Achieving Immunisation Outcomes (Maximum 3 pages)

Provide a description of the main health system bottlenecks. If such an analysis was conducted recently, provide ***optional Attachment No. 33:*** *Health system bottleneck analysis*

In spite of the ongoing efforts of the Government which is dedicating an increasing portion of its budget to healthcare (9.1% in 2011 to 12.6% in 2015) and of its development partners, significant difficulties remain with regard to the delivery of service, human resources for healthcare, procurement and supply management system, reliability of the health information system, efficacy of the sectoral dialogue and health care funding. Bottlenecks in the healthcare system that endanger the attainment of results in the area of immunisation are identified based on analysis of the status of the healthcare system. This analysis is based on the operation of reports (review of Gavi HSS2, mid-point assessment of the 2011-2020 NHDP, the 2015 action plan of the Ministry of Health, assessment of Effective Vaccine Management (EVM), joint assessment of the EPI, reports of national health accounts, sectoral performance reviews, the 2014 SARA survey, etc.).

- Leadership and governance

The right to healthcare is acknowledged by the Burkina Faso Constitution and it is stated in the public health code. Articles 60 to 71 of this code specify the right to immunisation. Leadership and governance to ensure this basic right is carried out via sectoral frameworks for dialogue and coordination at all levels of the health system.
Thus, at the central level, aside from the meetings of the Board of Directors of the ministerial sector (CASEM), the CS/NHDP and subject-specific committees of the 2011-2020 NHDP which are held regularly, frameworks specific to immunisation, i.e. the ICC and the EPI Technical Support Committee (TAG-EPI) are held.
At the intermediate level, the CRS/NHDP and the Regional technical health committees (CTRS) are instances of this cooperation.
At the peripheral level, District Health Centres and ECD/ICP/COGES meetings constitute statutory frameworks.
These regular meetings allow the health sector stakeholders (TFP, private and traditional healthcare sectors, civil society organisations working in the healthcare sector), social partners, municipalities, etc. to take an active part in examining the various reports on the planning, implementation and monitoring of activities at all levels of the system to guide decision-making in the healthcare area, including immunisation.
In spite of the existence of this governance process, several insufficiencies have been noted in the management of funding allocated by Gavi for health system strengthening together with immunisation. This specifically translates into poor reactivity to resolve difficulties with implementing complex activities, in particular major investments. This insufficiency was felt in the implementation, monitoring and evaluation of the intervention. This did not favour effective management of the implementation of immunisation activities [Gavi HSS2 review, July 2016].
Grass roots intervention that is insufficiently coordinated and standardised limit the effectiveness of

the contribution of grass roots organisations and community-based service agents to the implementation of healthcare activities, including immunisation. To this, we add the poor organisation and monitoring of the private sector in the fight against disease, including immunisation, which limits their contribution to the improvement of the status of residents' health.
The operation of technical and community structures involved in the implementation of health system strengthening activities linked to immunisation is not optimal. This situation could endanger the proper implementation of this grant.

- Provision of services

National vaccine coverage values increased from 99% in 2011 to 107% in 2015 for the Pentavalent 3 vaccine, from 74% to 106% for the PCV 3 vaccine, and from 74% in 2014 to 106% in 2015 for the Rota3 vaccine. The percentage of districts that attained Pentavalent 3 coverage greater than or equal to 80% was 98% in 2011 and 100% from 2012 through 2015 for an anticipated target of 99%. [2015 Statistics Yearbook] Fully immunised child coverage rates are satisfactory nationally (101.4% in 2015). However, in 28 out of 63 functional healthcare districts, children did not receive all the required vaccines. These 28 healthcare districts have a vaccine coverage rate below 100% for at least 2 vaccines (4 healthcare districts have a rate of between 84% and 90%, 9 have a rate of between 90% and 95% and 15 between 95% and 100%). WHO/Unicef estimates indicate poor performance for the measles vaccine (MV) and yellow fever vaccine (YFV) which have each presented 88% coverage in 2015.
In addition, according to the 2015 EMC-MDS, certain regions still present insufficient coverage. Thus, among children 12-23 months of age in the Sahel region, 43.2% were not fully immunised and 5.6% did not receive any vaccine (EMC-MDS 2015).
Furthermore, analysis of TT2 coverage among pregnant women also shows that eight (8) healthcare districts have not attained the 85% coverage level in 2015. They are the Toma (76.3%), Garango (75.0%), Ouargaye (72.5%), Tenkodogo (71.1%), Kaya (74.1%), Koudougou (70.2%), Kombissiri (68.6%), Manga (74.5%), Saponé (74.8%), and Boussé (73.0%) healthcare districts. [2015 Statistics Yearbook]
According to the cMYP, only 31% of children are immunised according to the advanced strategy. The organisation of this strategy encounters difficulties related primarily to vehicles being outdated and insufficient, and an insufficiency of qualified personnel. In addition to these 28 districts, there are 7 new healthcare districts that need support to become operational, so there are a total of 35 healthcare districts to be given support under this proposal.
Monitoring of the quality of services, in particular immunisation, at the community level, is insufficient, which affects advanced strategy activities, in the form of the number of missed appointments for immunisation sessions and dropouts. It has also been noted that the contribution of the private healthcare sector to immunisation activities is low. Their significant involvement could resolve the issues of immunisation of children in certain large urban centres.

- Workforce and human resources

In general human resources in healthcare are insufficient to provide care. The deficit involves the number of Government physicians and midwives/birth coaches with ratios below WHO standards. The 2015 statistics yearbook shows a ratio of 1 physician per 15,518 residents, 1 midwife/birth coach per 7,743 residents, compared to 1:10,000 and 1:5,000 residents.
In addition, of the 1,698 public Health and Social Promotion Centres where immunisation activities are conducted, 94.3% meet workforce standards. However certain regions such as the Central West (89.3%), Central North (87.8%), Central South (84.3%) and the Central Plateau (83.7%) are insufficiently staffed. This deficit is more acute in the healthcare districts of Koudougou (81.7%) and Léo (88,6%) in the Central West Region; Manga (73.0%) and Kombissiri (75,0%) in the Central South and Zorgho (66.0%) in the Central Plateau.

In addition, the low capacity of grass roots organisations and ASBCs to meet the needs of the people with regard to community healthcare, in particular immunisation, alongside healthcare services, is one of the major t concerns.

This situation is the result of:

- the absence of a strategy to create loyalty among agents in rural zones;
- the absence of an ongoing training plan;
- insufficient instructional and pedagogical material in training schools;
- insufficient skills for the management of immunisation and communication activities;
- insufficient specific supervision of healthcare agents in the implementation of immunisation activities in DRS and Healthcare Districts;
- failure to update skills of trainers in healthcare schools with regard to immunisation;
- poor quality of the training of healthcare agents in relation to the EPI in public and private healthcare training institutions.
- poor motivation of ASBC;
- poor ICC involvement in implementing immunisation activities..

In order to deal with this situation, the option of regionalising recruitment was adopted several years ago. In addition, an RHS development plan covering the period of 2013-2020 was adopted in 2013 in order to make the management, production and loyalty of human resources.

- Health promotion and disease control

In the context of health promotion, an integrated 2013-2015 communication plan regarding immunisation was implemented. It included routine immunisation, surveillance of target diseases, supplemental immunisation, and the introduction of new vaccines. According to the 2015 statistics yearbook of the Ministry, 53,951 IEC sessions on immunisation were conducted, which allowed 171,191 men and 1,002,503 women to be reached. This situation represents a weak mobilisation of men during immunisation awareness sessions. In addition, the plan experienced insufficient funding which caused poor media coverage, low procurement of communication equipment and tools for the EPI and insufficient strengthening of the capacities of field participants in the area of IEC/EPI (cMYP/1052
Also, the various assessments have shown poor collaboration between the EPI and Civil Society Organisations, low involvement of ASBCs and insufficient collaboration between public and private healthcare facilities.
The DPV performs surveillance activities of the EPI in collaboration with the reference laboratories. This surveillance is part of the strategy of integrated surveillance of the disease and the response under the oversight of the DLM. It involves the following diseases: poliomyelitis, measles, yellow fever, tetanus, whooping cough, Haemophilus Influenzae b meningitis, Pneumococcal meningitis, Rotavirus diarrhoea and congenital rubella Syndrome (SRC). The surveillance of diseases is carried out at all levels (peripheral, including the community level, intermediate and central) where focal points are appointed for its implementation. Nineteen (19) healthcare districts i.e. 30% have not attained the level of 2 cases of non-polio AFP and eleven (11) Healthcare Districts, i.e. 17%, have not attained the level of 80% of stools collected within 14 days. The analysis of congenital rubella syndrome surveillance data shows difficulties in the reporting of cases at the level of the sites as well as filling out the collection media (cMYP 2015). Under-reporting is due, among other items, to the insufficiency of financial resources, insufficient agent skills and absence of identification of priority sites in certain FS.

- Infrastructure, equipment and healthcare products

In Burkina Faso, the average theoretical radius of action (RMAT) decreased from 7.2 km in 2011 to 6.8 km in 2015. However it varies from 2.8 km for the Central region to 11.1 Km for the Sahel region.
For vaccine storage and management, DPV has ten (10) operational cold rooms. Each regional health directorate has facilities and a positive cold room for vaccine inventory and supplies. Similarly, each health district as well as most of the Health and Social Promotion Centres (CSPS/CM) have a facility and refrigerators/freezers for storing vaccines and supplies.

The procurement of equipment and vehicles is carried out via a contract approval process, the financial aspect of which is covered by the Government and its partners. Maintenance of this equipment is provided via contract with the private sector and maintenance workshops at the level of the health regions.
At the level of supplies, the vaccine, medication and consumables supply process is part of the procurement policy for pharmaceutical products put in place by the health system, funding for which

comes from the Government and its technical and financial partners, including Gavi. Each year, since 1996, a guaranteed budget line item the account for which is maintained at the central procurement office of Unicef (Copenhagen). [sic] Unicef negotiates procurement prices and allows the Burkina Faso government to guarantee ongoing availability of vaccines and other supplies.
Vaccines are distributed quarterly or semi-annually, based on storage capacities of the regional and district warehouses. The Health and Social Promotion Centres are resupplied monthly by the healthcare districts.
However in 2015, difficulties were observed in the management of vaccine and consumable stocks. They resulted, among other items, in significant wastage of doses of the Pentavalent vaccine and stockouts of BCG, YFV and safety boxes. These difficulties were related to insufficient supply chain management, and more specifically that of the vaccines and the cold chain.
Furthermore, the issue of availability and the accessibility of medications and working kits for the ASBC is a significant concern for the health system. For this proposal this involves ensuring the strengthening of capacities for community-based services. The resupply process for medications, consumables and work kits will also include the HDSP procurement plan, the funds for which come from the Government, Gavi and its technical and financial partners.

The primary bottlenecks are:

- the absence or non-operational condition of continuous temperature recorders in the installed cold rooms;
- the outdated condition of cold rooms at the central and regional levels causing frequent breakdowns;
- insufficient cold rooms at the central and local levels to house them;
- poor storage capacity in dry stores in most regional and district stores;
- insufficient preventive maintenance and repairs;
- lack of understanding by EPI agents of vaccine storage procedures, how to perform a shake test, and packaging cold packs for transport;
- lack of practices for the routine review of temperatures and vaccine wastage to take corrective measures;
- lack of maintenance plans for buildings and other EPI infrastructure at all levels;
- inadequate formative supervision for agents at all levels in EPI logistics management;
- poor quality of data collected regarding inventory management, failure to control inventory management, deterioration of supplies, and supply stockouts;
- insufficient vehicle logistics for the transport of supplies;
- insufficient advanced strategy, supervision and control activities and high expenses involved in leasing a warehouse;
- excess full safety box storage in the districts and healthcare facilities, the presence of insufficiently destroyed waste around the incinerators in use.
- insufficient management of medication, consumables at the level of community-based services (ASBC);
- lack of equipment for Community-based Services and Civil Society Organisations.

- Health Information System.

The health information system is included in the strategic documents such as the 2011-2020 NHDP and the 2016-2020 cMYP. The collection, quality control of data, analysis and transmission of data are described in the cMYP and in strategic guideline No. 6 - "Improved management of the health information system" of the NHDP.
In the domain of the EPI, particular emphasis is placed on the design, coordination, planning, monitoring and assessment of immunisation activities on the one hand, and on epidemiological monitoring of EPI targeted diseases, on the other hand.
Data collection tools are primarily the log books, log sheets, records and activity reports. The health data bank "Endos-BF" is the tool used to process and store routine healthcare district data (including EPI data).
In regional health directorates and health districts, EPI data quality self-assessments (DQS) also take place semi-annually. The survey of service availability and operational capacity of structures (SARA) that is conducted every two years considers immunisation data. This survey revealed an insufficient concordance of data at a level of 93.6% (Data quality survey, 2015). The in-depth EPI review is

conducted every 5 years in order to evaluate the programme, make recommendations for its strengthening and its ongoing existence. One aspect of this review is the assessment/evaluation of the level of vaccine coverage indicators.
The review and the availability of tools at healthcare facilities have allowed the promptness rate of monthly EPI reports during the last 3 years to be improved. It remained within the WHO standard, which is 80 to 100%. The completeness of reports sent in the past three years was 100%.

Specific attention was paid to the quality of data from community-based services and the private sector. National Health Information System data collection tools were revised in function of the information requirements of community participants (grass roots organisations, ASBC) and the private sector. In order to do so, the relevant interventions were proposed in order to ensure the quality of data, as well as the promptness and completeness of data at the private and community level.

However, from an analysis of reports from the 2015 review of the health sector, the mid-point assessment of the 2011-2020 NHDP and the 2016-2020 cMYP, the following bottlenecks were identified:

- insufficient skills on the part of actors in the use of the Endos-BF database;
- poor skills of private organisation and community actors in regard to data management;
- non-availability of a high-capacity server for data storage;
- insufficiency of the high-speed internet connection at central, intermediate and peripheral facilities;
- non-availability of a second server to be used as a mirror;
- poor performance of surveillance of EPI target diseases;
- frequent stockouts of data collection media in general, including those for immunisation;
- insufficiencies in the data quality self-assessment (DQS) for the EPI;
- poor completeness of health facility data;
- insufficient skills of personnel responsible for data collection and management;
- poor quality of data collected, including data on immunisation at the level of public, private and community health care facilities;
- insufficiency in the dissemination of health information;
- insufficient collection and capitalisation of immunisation activities by the community sector and NGOs/Associations;
- insufficient regional executives for immunisation data validation;
- insufficient computer equipment;
- multiplicity and lack of mastery of data collection and reporting tools by the participants in question.

The consequences of these bottlenecks are, among others, poor reaction capacity on the part of the Ministry for decision-making; poor EPI performance and its impact on the reduction of morbidity and mortality from vaccine-preventable .
In order to decrease the effect of these bottlenecks, actions have been implemented, in particular activities for performing data quality control (DQS, LQAS), for strengthening capacities of participants and reproduction of data collection media.

- Health research

Research centres and institutes, University Hospital Centres/Regional Hospital Centres, Regional Health Directorates and Healthcare Districts conduct research activities into varied subject areas, including immunisation.

However they are faced with difficulties that block the dynamism of research, such as:

- insufficient skill in the domain of health research;
- insufficient production of scientific evidence related to immunisation;
- poor capitalisation of results of health research with regard to immunisation;
- insufficient distribution and use of results from research in the health field;
- insufficient funding in support of research;
- poor collaboration by research centres with the DPV in the production of scientific evidence intended to resolve health problems specific to immunisation.

The consequences of these bottlenecks are, among others, failure to complete certain research work related to immunisation.

- Health funding

The financial resources mobilised for implementation of the NHDP come from the State and partners.

In spite of the progress observed with regard to funding, we have noted:
- insufficient financial resources for implementing operational immunisation activities and the procurement of logistics, particularly vehicles and computer equipment;
- insufficient management of financial resources mobilised in support of immunisation.
- insufficient harmonisation of funding contributions by partners at the Ministry of Health level.

- Coverage and equity of access to immunisation

Burkina Faso has not prepared an equity plan for immunisation. However the supply of immunisation is based on equity, based on the values of the national health policy. The right to health is acknowledged by the Constitution dated 2 June 1991. The values that underlie the current national policy are: equity, social justice, solidarity, accountability, ethics, integrity, respect for the cultural identify of communities and patient rights as well as the gender policy and good governance.

Articles 60 to 71 of this code specify the right to immunisation. Within the NHP vision, immunisation interventions are implemented on the national scale so as to avoid any exclusion situation. Immunisation is a high-impact intervention for reducing maternal and neonatal mortality and is entirely free of charge. Immunisation services are available in rural as well as urban areas. The theoretical radius of access to a healthcare facility (RMAT) decreased from 7 km in 2013 to 6,8 km in 2015 (Source: 2015Statistical yearbook). The proportion of the population located more than 5 km from a healthcare facility corresponding to the portion of the population enjoying the advanced immunisation strategy was 49.5% in 2015. Boys and girls have equal opportunities for access to immunisation services. The advanced immunisation strategy allows coverage of populations located beyond a radius of five (5) kilometres from a health care facility. Since late 2013, new routine EPI data collection media have allowed reporting of immunisation data based on sex, distance from a healthcare facility at all levels of the system
In 2015, vaccine coverage was nearly equivalent for boys/girls (100.35% and 102.67%). They vary based on region, however there is no great disparity between urban and rural zones.
As a result the 28 Health Districts with low performance, representing 44% of the HD 21, i.e. 75% post a difference of -1.67 in vaccine coverage with Penta3 between boys and girls. In spite of this small, relative difference, it must be noted that in practice, there is no discrimination with regard to immunisation based on gender, as witnessed by districts where girls receive more vaccines than boys and vice versa.
Analysis of vaccine coverage data in a disaggregated manner by vaccine strategy (advanced and stationary strategy) by village and by sex, in order to better determine specific problems by level have allowed identification of the regions and districts with low performance values. (Cf. attachment, "Criteria and statistical data from 28 Health Districts with low performance and 7 new Health Districts".

In summary, Gavi support to strengthen the health system will contribute to improving access to and equity of immunisation services.
A statistical analysis of vaccine coverage by sex and immunisation strategy is attached.
According to the 2009 in-depth assessment of the EPI, the reasons for non-immunisation are primarily linked to insufficiencies with regard to knowledge about the importance of immunisation (21%); poor knowledge of the immunisation schedule (38%); unfamiliarity with the need to return for subsequent doses (16%); being unaware of the place and time of the session (12%); absence of the vaccinating agent and fear of side effects (13%). Similarly, the reports from supervisions have shown that the continued existence of non-immunised children is linked to poor coverage of specific zones (disadvantaged zones, markets, gold panning areas, cultural hamlets, border zones, etc.) and insufficient searches for children who miss immunisation sessions; in addition, these reports note the poor skills of health care agents with regard to the EPI, based on their constant mobility and poor implementation of support (supervision, etc.), poor vaccine storage capacity at all levels due to the introduction of new vaccines; insufficient Cold Chain equipment due to certain refrigerated equipment

being outdated, interruption of the cold chain due to electrical generating groups not being available to cold room links between the DRS and the districts, insufficient implementation of advanced strategies and supervision due to insufficient 2- and 4-wheel vehicle logistics and insufficient implementation of communication activities in support of immunisation due to the poor funding for communication activities and insufficient involvement by external actors;
These reasons show that the causes for non-immunisation are linked to programme management and not to inequality in the delivery of immunisation services. It is in this regard that actions related to these bottlenecks have been planned in the framework of the application. Regardless of the period and immunisation in question, the girl/boy coverage ratios are very close to equal: 0.99 for BCG and 1.08 for complete vaccine coverage. The discrepancies are not significant.

Pooled fund *applicants are required to provide a reference to the relevant section and pages in the NHSP which outline how lessons learned from the previous NHSP have been incorporated into the current NHSP plan. If available, attach documentation on lessons learned implementation of the pooled funding mechanism, including relevant sections from joint annual reviews (JAR), mid-term evaluations etc.*

11. Health system bottlenecks to be targeted through Gavi HSS support (Maximum 2 pages)

Identify which of the bottlenecks identified in Question 10 above will be targeted through Gavi HSS support.

The primary bottlenecks listed below result from an analysis of the situation and the actions for which will be described and submitted in this application.

Leadership and governance

- operational insufficiency of the EPI coordination bodies and support structures for the implementation of the grant;
- poor involvement of civil society, the private sector and the community sphere in immunisation activities;
- insufficient planning, monitoring and assessment of Gavi HSS activities.

Provision of services

- insufficient integrated and specific EPI supervisions;
- insufficient vaccine coverage in certain health districts;
- insufficient implementation of immunisation strategies;
- insufficient monitoring of immunisation data.

Workforce and human resources

- insufficient instructional material in the area of immunisation for public and private training schools;
- insufficient skills for implementation of immunisation and communication activities.

Health promotion and disease control

- insufficient application of the surveillance guidelines for EPI-targeted diseases;
- poor performance by certain districts in surveillance of AFP, measles and neonatal tetanus and yellow fever;
- insufficient implementation of active searches for vaccine-preventable diseases (MEV);
- insufficient community involvement in the surveillance of vaccine-preventable diseases;
- insufficient implementation of communication strategies; and
- poor mobilisation of people in support of immunisation activities.

Infrastructure, equipment and healthcare products

- insufficient vaccine management;
- insufficient storage capacity;

- outdated condition of certain cold rooms at the central and regional levels;
- insufficient supervision vehicles at the central, regional and district levels;
- insufficient logistics vehicles for health care facilities;
- insufficient high-capacity computers necessary for operational use of the vaccine management tool (DVD/MT) at all levels;
- insufficient cold room maintenance at the central level and in certain regional departments;
- insufficient cold rooms at the central and local levels to house them;
- insufficient/lack of refrigerators in CSPS/CM.

Health Information System.

- poor data quality, including immunisation data, which is explained by:
    - insufficient skills of EPI supervisors from the DRS and Healthcare Districts in the use of the Endos-BF database;
    - poor availability of immunisation data collection materials, including those for immunisation;
    - insufficiencies in the data quality self-assessment (DQS) for the EPI;
    - insufficient skills of personnel responsible for data collection and management;
    - the non-availability of a connection with sufficient bandwidth to ensure the entry of data into the Endos-BF database;
    - insufficient collection and capitalisation of immunisation activities by the private sector, community sector and NGOs/Associations;
    - insufficient regional executives for immunisation data validation;
    - insufficient regular analysis of vaccine stock management indicators;
    - insufficiently regular analysis of district-level performance indicators;
    - insufficiently regular feedback;
    - insufficiency and/or absence of surveillance data validation;

Health funding

- insufficient harmonisation of funding contributions by partners at the Ministry of Health level.

This application is intended to mobilise funds to implement actions that will contribute to health system strengthening in order to improve the quality of healthcare services provided.

In addition, the Ministry of Health has undertaken the standardisation of contributions by the various technical and financial partners to strengthen the health system. The objective was to identify complementarities and opportunities for optimising funds that were available or potentially available through 2020. It was in this context that a meeting held in March 2016 allowed the fields for intervention by the TFPs to be determined, in order to ensure efficient use of the pooled funds from partners (Gavi, Global Fund, European Union, Unicef, WHO, etc.).
For the priority populations and zones that were "not selected" in this proposal, the national results-oriented planning system provides a global view of the needs to be met to cover all the health programs of the country. Therefore, the Government, in its annual budget for the healthcare sector (12.6% in 2015) and the other partners will cover the funding needs contained in the annual action plans for the facilities. (Cf. report from the Gavi-Global Fund harmonisation workshop).

Pooled fund applicants *are not required to complete this question.*

12. Objectives of the NHDP and application (Maximum 2 pages)

Present specific objectives to address the identified bottlenecks, explaining how each aligns with objectives in the cMYP and/ or specific health system strengthening policies/ strategies being implemented. These objectives must be listed in the same order in ***Attachment No. 6*** *- detailed work plan, budget and gap analysis.*

Pooled fund applicants *are not required to prepare separate objectives, rather to list the key objectives from the NHDP, including ones relevant to immunisation.*

Objectives	Description
Objective 1: Strengthen coordination, monitoring and assessment of the health system from 2017 through 2021	This objective is linked to strategic guidelines Nos. 1, 3 and 8 of the NHDP in its intervention axes 1.1.1, 1.1.2, 1.2.1, 3.2.1 and 8.1.2 An analysis of the situation conducted in the cMYP with regard to the EPI demonstrated insufficiencies in the domains of leadership and governance, human resources and funding. Attainment of this objective passes through the performance of the corresponding activities.
Objective 2: Improve the delivery of immunisation services by increasing the percentage of districts with a 100% fully immunised child rate from 55.5% to 90% through 2021.	This objective is linked to intervention axes 2.1.2, 3.2.1, 4.1.1 and 4.2.1 of the NHDP. It is also related to the objective of "attaining at least 90% vaccine coverage for all antigens in all Health Districts through 2020" of the cMYP. The insufficiency in the use of immunisation services justifies the low proportion of districts with a 100% fully immunised child rate and constitutes an obstacle to the improvement of mother's and child's health. In order to attain this objective, it will be necessary to strengthen immunisation according to fixed and advanced strategies, immunisation in major markets and in refugee camps, active search for dropouts at the central level and in districts with low vaccine coverage and communication in support of the EPI. In addition, emphasis will be placed on supervision, control of effectiveness of the advanced strategy and strengthening of the skills of agents and AEFI surveillance. Support from Gavi for the implementation of this objective will allow an improvement in service delivery and strengthening of communication actions in the field of immunisation.
Objective 3: Increase the routine immunisation data consistency index from 93.6% to 97% through the end of 2021;	This objective is tied to the axes of intervention 6.1.1 and 6.2.1 of the NHDP and the specific objective of "Improving immunisation data quality through 2020" of the 2016-2020 cMYP. Attainment of this objective passes through the provision of harmonised data collection media to public and private healthcare facilities, quality control of data at all levels, availability of a high-speed internet connection for entering data, training participants and organising data validation meetings at the regional and district level, including NGO/Association data. Gavi's contribution will allow data quality to be enhanced.
Objective 4: Strengthen the management of the supply chain for vaccines, consumables and logistics at all levels.	This objective is tied to the axes of intervention 5.1.1 and 5.2.1 and 5.3.1 of the NHDP and the specific objective of "Strengthening vaccine and consumable management through 2020" of the 2016-2020 cMYP. The objective targets the strengthening of the capacities of agents in the management of supplies, maintenance and the acquisition of vehicles, cold chain and computer equipment. The Gavi contribution will allow the system for resupply and management of vaccines to be enhanced.

13. Description of activities (Maximum 3 pages)

Describe the key activities which will lead to achievement of objectives set out in Question 12. Please ensure that the activities described align with the activities ***that are included in Attachment #6*** *- Detailed budget, gap analysis and work plan.*

Pooled fund applicants are not required to complete this table, but should provide relevant sub-sections of the NHSP focusing on immunisation, including the annual workplan, activities and budget; ***Attachment #34:*** *Pooled fund Annual Workplan and Budget (AWPB) and related Terms of Reference (TORs).*

❖ Description of Activities	
Objective / Activity	**Explanation of link to improving immunisation outcomes**
Objective 1: Strengthen coordination, monitoring and assessment of the health system from 2017 through 2021	
Activity 1.1: Cover the operation of a programme team within the National Platform of NGOs/Associations in support of vaccination and immunisation for better involvement in the implementation of Gavi HSS activities from 2017 through 2021	This will involve implementing and ensuring the operation of a 4-member team charged with coordination at the central level and a 39-member team charged with coordination at the regional level for actual involvement by civil society. Two (2) representatives per region plus the central level will meet once every six months for 2 days at Ouagadougou in order to refine the implementation of the grant.
Activity 1.2: Hold quarterly ICC meetings from 2017 through 2021	Chaired by the Minister of Health, each of these four (4) meetings per year will bring together 22 members representing structures including the technical and financial partners, civil society, decision-makers and technicians from the Ministry of Health working in the field of the EPI. Performance of this activity allows major decisions to be made and funds to be mobilised in support of the EPI.
Activity 1.3: Hold quarterly TAG-EPI meetings from 2017 through 2021	The TAG is the ultimate technical entity of the EPI. Holding meetings bringing together representatives of WHO, Unicef, Rotary Club, the Preventive Medicine Agency (AMP) and under the DPV, intended to give technical opinions related to the EPI for holding the ICC meetings.
Activity 1.4 : Support the operation of the technical monitoring and assessment committee for implementation of the grant from 2017 through 2021	This activity comprises two (2) aspects: holding quarterly meetings of the technical committee consisting of ten (10) members and the provision of office supplies, computer consumables and equipment. Completion of this activity will allow the implementation of the grant.
Activity 1.5 : Support the operation of the grant management office (HDSP) from 2017 through 2021	This activity will allow the management office to contribute to coverage of various operating expenses of the structure. Its performance will allow operation to be strengthened and the grant to be better managed with the contribution of other Technical and Financial Partners, i.e.: GF, WB, WHO, UNICEF, UNFPA, AFD, etc.
Activity 1.6: Train 2 members of the HDSP Management Unit and 23 participants from the central and regional levels in results-oriented planning in Ouagadougou, in 2018	Training of participants in results-oriented planning will allow better monitoring of the implementation of the proposal. This will take place at a session in 2018 in Ouagadougou
Activity 1.7: Contribute to the expenses for 3 agents hired (two accountants and one internal auditor) for Management Unit-HDSP	This will involve contributing, together with the other Technical and Financial Partners (GF, WB, AFD, etc.) to the coverage of the supplemental work expenses for 3 agents from the management office committed in the application management tasks.

Activity 1.8: Train 2 members of the Technical Committee in monitoring and assessment of projects and programs at CESAG in Dakar in 2017 and 2018	This will involve covering registration charges, transport and meals for 2 members for 2 years. Training of members of the Technical monitoring and assessment committee will allow this team to strengthen its skills for better monitoring of the implementation of the proposal.
Activity 1.9: Conduct an internal mid-term assessment of the proposal in 2018	This will involve an internal assessment by the members of the technical monitoring and assessment committee and an evaluation based on the summary of on-site visit reports. It will allow performance to be assessed, bottlenecks to be eliminated and recommendations to be made for better implementation of the proposal.
Activity 1.10: Organise a final external evaluation of the proposal in 2021	This will involve an external evaluation by a research firm/consultant. This will allow an evaluation of the performance attained, formulation of recommendations and to glean lessons for future applications.
Activity 1.11: Organise one (1) annual meeting for the dialogue framework involving civil society, the private healthcare sector and the Ministry of Health in the context of strengthening of immunisation activities from 2017 through 2021	This meeting will bring together 15 representatives of the Ministry of Health, 10 from civil society and 10 from the private sector in Ouagadougou to refine their collaboration in the field of immunisation in a one-day workshop.
Activity 1.12: Conduct quarterly visits to monitor implementation of Gavi HSS activities from 2017 to 2021	This activity consists of mobilising five (5) teams of three (3) members each, to monitor the implementation of the proposal in the DRS and Healthcare Districts including the Health and Social Promotion Committees
Activity 1.13: Support inspection and internal audits for the management of Gavi-HSS funds from 2017 through 2021	This activity will allow the levels of disbursement and absorption of funds mobilised to be monitored regularly, and the regularity of expenses and possibly to provide advice to allow funds to be used better. It is carried out with the financial oversight of other partners (GF, WB, WHO, Unicef, UNFPA, BM, OMS, UNICEF, UNFPA, AFD, etc.)
Activity 1.14: Support the funding sessions for annual action plans for structures of the Ministry of Health from 2017 through 2021	This involves two (2) funding sessions per year. An initial session in which 7, 4-member teams, each for the central level, travel to the Regional Health Directorates to prepare balance sheets of the actions o all the structures of the Ministry of Health for the past year and to serve as the shelter for new activities to be funded for the current year. The second session, as the first, consists of preparing a mid-point inventory of the activities carried out and allocate funds for those to be carried out. These sessions could be held with the financial monitoring by the other partners.
Activity 1.15: Conduct an independent survey by civil society regarding immunisation in the field in 2019	This activity will consist of collecting data on the implementation of immunisation for a diagnostic of the platform on procurements and the insufficiencies in the performance of immunisation. Upon completion of this collection, a workshop for the preparation of a draft report by the PN/OSV will be held in Koudougou for 5 days and a validation workshop for the 40 members of the platform for one day in Ouagadougou.

Activity 1.16: Contribute to the financial audit expenses for the project for 2017 through 2021	This activity consists of verifying the regularity, accuracy of expense items and compliance with the HDSP management procedure manual and the regulations/laws related to expenses. It was carried out with the financial monitoring of the partners whose funding goes through HDSP.
Activity 1.17: Cover the production of periodic reports on the Gavi HSS grant from 2017 through 2021	This activity consists of generating the periodic Gavi reports The report will allow the performance status of the activities to be presented and the disbursement of funds to be facilitated on-time.
Activity 1.18: Prepare the next application (Gavi-HSS 4) in 2021	This will involve considering the results of Gavi/HSS_3 assessments and to prepare the Gavi/HSS_4 report. This activity will allow the time between applications to be shortened.
Activity 1.19: Support the semi-annual integrated supervisions in the 70 Healthcare Districts from 2017 through 2021	This involves semi-annually allocating fuel to each of 70 HDs for supervision by agents of the Health and Social Promotion Centres. This activity will strengthen the skills of agents for implementation of the minimum package of activities (PMA)
Activity 1.20: Organise a meeting of Gavi-HSS focal points expanded to the Technical and Financial Partners every 2 months from 2017 to 2021	This involves organising a meeting for focal points expanded to the TFP every 2 months. This activity will allow better monitoring of the Gavi-HSS activities and the needs for consistency among the versions to be answered for actions performed regularly, joint balance sheets and the monitoring of the implementation of the application activities.
Activity 1.21: Support the regions and the Healthcare Districts in the preparation of results-oriented action plans integrating immunisation from 2018 through 2021	The Ministry of Health adopted the results-oriented planning approach. This support will allow resource persons (3 per region) to support the preparation of action plans each year.
Objective 2: Improve the delivery of immunisation services by increasing the percentage of districts with a 100% fully immunised child rate from 55.5% to 90% through 2021.	
Activity 2.1: Support the semi-annual specific supervisions of the EPI at the DRS, Healthcare District and private healthcare facility levels from 2017 through 2021	This will involve conducting specific supervisions of the agents responsible for immunisation respectively by DRS (70 DS and 140 CSPC) and by the DS (1689 health and social promotion centres, private structures performing immunisations).
Activity 2.2: Conduct immunisation using advanced strategies in 990 Health and Social Promotion Centres (CSPS) in the 28 districts with low vaccine coverage and 7 new Healthcare Districts (gold panning and refugee sites, farming hamlets, border zones, markets, etc.) from 2017 through 2021	This will involve immunising children living in gold panning zones and refugee camps, cultural hamlets and border areas and that escape routine immunisation. Gavi support supplements the contributions of the other partners.
Activity 2.3: Carry out a monthly visit to inspect the effectiveness of advanced immunisation strategy in 2 villages in each of the 70 Health Districts by the ECD, from 2017 through 2021	Programs for immunisation visits are prepared each month by the healthcare facility agents and they are then sent to the district executive team. This activity allows the District Executive Team to ensure the effectiveness of implementation of the strategy in the field
Activity 2.4: Organise quarterly meeting of the national oversight commission and the oversight committee on vaccines and other biological products in 2018 and 2019	Regularly holding the 04 annual sessions of the vaccine oversight committee and the national oversight commission for better treatment and the attribution of AEFI notifications.
Activity 2.5: Organise additional research missions for serious AEFI cases from 2017 through 2021	This activity will allow the committee to carry out investigation visits and serious AEFIs reported and the analysis of their applicability.

Activity 2.6: Organise 3, 5-day sessions for training EPI and CISSE supervisors from the DRS and Healthcare Districts in EPI management in 2017 and in 2019	In order to offset the insufficiencies observed (insufficient skills of participants, poor effectiveness of vaccine strategies), the strengthening of the skills of actors in the area of EPI management will allow their knowledge to be updated and to thus ensure the continuity of quality immunisation services.
Activity 2.7: Organise 70, 5-day sessions for training health agents in EPI management in 2017 and in 2019.	
Activity 2.8: Organise the training of a pool of 10 participants responsible for immunisation during the mid-level management course on the EPI (MLM/EPI) in Burkina Faso, in 2018.	This involves using the pool of existing trainers to strengthen the managerial capacities of the participants charged with EPI management at the central, regional and peripheral levels.
Activity 2.9: Procure 8 supervision vehicles (2 station wagons and 6 extended cab pick-up trucks) for the DPV (2), the Healthcare Districts (5) and civil society (1) in 2018 and 2020	This involves procuring, to supplement the amounts budgeted by the Global Fund HSS, 2 vehicles for the DPV, 5 for the Healthcare District and 1 for civil society. The availability of these vehicles will allow the teams from the central level, district executive teams and civil society to strengthen supervisions.
Activity 2.10: Equip 16 training schools, 6 of which are public and 10 of which are private, with instructional materials in 2019	This will involve equipping each of the 6 public and 10 private sector training schools, with an immunisation guide, mannequin, an updated vaccine schedule poster mannequin in order to appropriately ensure practical courses during immunisation.
Activity 2.11: Conduct 2 lobbying sessions in support of immunisation with religious leaders, traditional and community leaders from 28 healthcare districts with low performance and 7 new Healthcare districts in 2017 and 2020	Since opinion leaders are resource personnel, the PN/OSV will organise advocacy meetings on immunisation in 2017 and 2020. They will provide contact persons in the mobilisation of populations in general and men in particular in the 28 Healthcare Districts with low performance and 7 new Healthcare Districts.
Activity 2.12: Train 13 members of the national platform of NGOs and associations in support of immunisation (PNOSV) in immunisation-related communication for 3 days in 2017 and 2019	This will involve organising one per year in Bobo, one training session in communications benefiting civil society participants accompanying the implementation of the EPI to strengthen their capacity for mobilisation in favour of immunisation.
Activity 2.13: Conduct IEC/CCC sessions where the population of the 28 health districts with low performance and the 7 new districts regarding immunisation from 2017 through 2021.	To change the behaviour of populations for their effective compliance with immunisation. Educational chats, film showings in the 28 healthcare districts with poor performance and the 7 new districts. A particular focus will be given to AEFI management during the staff training.
Objective 3: Increase the routine immunisation data consistency index from 93.6% to 97% through the end of 2021;	
Activity 3.1: Conduct a semi-annual DQS at the level of the DRS and Healthcare Districts from 2017 through 2021	This involves performing one DQS per semester at the level of each DRS (13) and Healthcare Districts (70).
Activity 3.2: Cover the reproduction of media and tools for data collection for the SNIS and the EPI at the level of the healthcare districts in 2017 and 2019	This involves equipping 70 health districts with media and instruments for the connection of data from the SNIS and the EPI
Activity 3.3: Procure, install high-speed connection kits and cover the subscription fees for the DRS, Healthcare Districts, DPV and the DSS for the entry of data into ENDOS (DHIS2) from 2017 through 2021	To supplement the allocation from the HSS-Global fund, this proposal will equip 5 DRS, 28 Healthcare Districts, the DPV and the DSS in high-speed connection kits in order to increase the completeness of data.

Activity 3.4: Train 15 members of NGOs/Associations and 15 agents from private facilities on the SNIS in one 5-day session in 2018 and 2019	This involves strengthening the skills of 15 members o NGOs/Associations and 15 agents from private health structure on the National Health Information System. This action supplements the intervention of the Global Fund HSS.
Activity 3.5: Train 20 new agents from each district in filling out the SNIS tools in one 3-day session in 2017 and 2020	This involves training new health agents from public and private structures in health care to fill out the SNIS tools, to supplement Unicef participation in the context of the implementation of the 2016-2020 cMYP.
Objective 4: Strengthen the management of the supply chain for vaccines, consumables and logistics at all levels.	
Activity 4.1: Procure 405 motorbikes for the Health and Social Promotion Centres in 2017	This will involve procuring 405 motorbikes for the advanced immunisation strategy of the SANILI 125 brand. The beneficiaries of the Health and Social Centres are those of the 28 districts that have the lowest vaccine coverage rates and the 7 new districts.
Activity 4.2: Procure 13 motorbikes for civil society in 2017	This will involve the provision by civil society of 13 motorbikes for structures participating in immunisation, to supplement the Global Fund HSS allocation. These motorbikes will allow them to implement monitoring and supervision activities of civil society at the level of their region and to participate in control of the effectiveness of the advanced strategy implementation.
Activity 4.3: Procure 13 approved freezers for the Regional Health Directorates, 60 freezers, 70 approved VLS 400A refrigerators and 30 solar refrigerators for the Healthcare Districts and 177 approved solar/electric refrigerators, Model TCW 2043 SDD for the Health and Social Promotion Centres, in 2018 through 2021	This involves acquiring, for each of the 13 regional directorates, 1 approved freezer and 1 for each of the 60 health districts having a permanent connection to electrical power, of the Vestfrost MF314 model. This also involves acquiring for the 70 Healthcare Districts, 70 VESTFROST VLS400A Greenline (PQS Code E003/065) refrigerator, and 30 Vestfrost Model VLS 154 SDD Greenline (PQS Code E003/054) approved. Lastly, this involves procuring 177 B Medical (DOMETIC) Model TCW 2043 SDD (PQS Code E003/043) solar refrigerators approved for the CSPS.
Activity 4.4: Procure 2 electrical generators for the DPV and 13 solar power kits for DRS cold rooms in 2019	This will involve procuring 2 high-capacity 50 kVa electrical generating groups and one solar power kit (solar panels, batteries, etc.) for each of the 13 regional directorates for better vaccine conservation.
Activity 4.5: Procure 2 trucks for the DPV in 2018	This will involve procuring 1 refrigerated truck and one 10-ton truck for the DPV for resupplying regions. Procurement of these trucks will contribute to ensuring the ongoing availability of vaccines in the healthcare districts.
Activity 4.6: Cover the training of 83 agents, including 13 EPI supervisors from regions and 70 EPI supervisors from districts regarding preventive cold chain maintenance in 2017 and 2019	This activity consists of training 1 EPI supervisor from the 13 DRS and 1 EPI supervisor in each of the 70 districts in preventive cold chain maintenance. This will allow ensuring proper cold chain monitoring.
Activity 4.7: Cover repairs to 10 cold rooms of the	This activity consists of preparing a contract for

DPV and 13 regional cold rooms from 2017 through 2021	services between the DPV and a competent entity that performs maintenance to take care of the cold rooms. Likewise, each of the 13 DRS will establish a maintenance agreement with a competent entity to maintain the cold rooms. These maintenance agreements will include the procurement of spare parts and the purchase of protection equipment (voltage stabilisers). The Gavi contribution supports the maintenance actions covered by the Government budget. In the context of this proposal, the country will require 2 technical assistance contracts in the fields of procurement/management of cold chain equipment and strengthening of skills for logistics. For the procurement of cold chain equipment, Unicef provides technical support while WHO provides assistance in the strengthening of skills. Thus no technical assistance aspect was budgeted in the context of this application.
Activity 4.8: Each year, cover the control/inspection of EPI warehouses (central and regional) regarding good vaccine and supply management practices for 2017 to 2021	This will involve the DGPML making control/inspection visits each year, according to 6 axes, lasting 5 days. These visits will be preceded by a briefing and tools standardisation meeting lasting 3 days for capacity building for the 13 regional pharmacists and those of the central are for vaccine control/inspection. The performance of this activity will in time allow compliance with storage best practices to be respected, as well as distribution in the daily management of vaccines, thus improving the quality of the vaccines distributed.
Activity 4.9: Cover independent oversight of vaccine and supply availability at the healthcare facilities by civil society.	For the regional focal points of the PN/OSV-BF this will involve collecting data on the availability of vaccines and supplies at healthcare facilities in order to detect and document any stockouts involving these supplies. To this end, a platform representative will be dedicated to this task in each district, i.e. 70 participants. Semi-annual visits by the central level team will be organised. Lobbying activities directed at decision makers may be implemented in the event of an alert.

How will activities have an impact on the socio-geographic, cultural and gender equity dimensions.

From the start, immunisation is free throughout the entirety of Burkina Faso territory, erasing socio-economic disparities for access to vaccines.
The continuation to offer immunisation with the advanced strategy at all centres for healthcare and social promotion in the country, advanced strategy operations for immunisation that will be carried out in the specific zones, (disadvantaged zones, contracts, gold panning sites, cultural hamlets, cross-border zones, etc.) will allow geographic inequities.
The offer of healthcare services in general and that of immunisation services based on values of the national health policy, which values are shared by all agents, is offered to any person without distinction as to race, religion, origin and socio-economic level, witnesses the embrace of socio-cultural equality
Routine proximity communication regarding immunisation sites, proximity communication among the

population including those planned in the context of this proposal will allow hesitant parties to become aware and to refuse immunisation.

Strengthening of skills (trainings, supervisions, controls, cooperations, monitoring, etc.) of the various participants and other activities planned in the context of this proposal will make the offering of quality immunisation services available to the entire population.

14. Results chain (Maximum 4 pages)

*Complete the **Results Chain** using the template provided below. For each objective specified in Question 12, provide information on: (i) activities (as noted in Question 13); (ii) intermediate results; (iii) immunisation outcomes; (iv) impact; and (v) assumptions for the achievement of results.*

*Once the Results Chain has been developed, the next step is to complete the **Performance Framework** (for all HSS applications i.e. including for applications for pooled fund support). This can be accessed through the Gavi country portal: www.gavi.org*

*Pooled fund **applicants** are not required to complete this template, but must provide a a summary of how Gavi HSS funds will contribute to improving immunisation outcomes in the context of the NHDP.*

Results chain		
***Objective 1:* Strengthen coordination, monitoring and assessment of the health system from 2017 through 2021**		
Key Activities: ▪ *Hold quarterly ICC meetings from 2017 through 2021* ▪ *Conduct quarterly visits to monitor implementation of Gavi HSS activities from 2017 to 2021* ▪ *Support inspection and internal audits for the management of Gavi-HSS funds from 2017 through 2021*	***Intermediate Results:*** ▪ *95% of EPI funding is mobilised* ▪ *Effective introduction of new vaccines: IPV, MenAfriVac (2017)* ▪ *100% of facilities have a physical and financial management score of at least 80% (71% in 2015).* ▪ *100% of ICC and CTA meetings held with validated minutes.*	***Immunisation Outcomes:*** ▪ ***100% of surviving children who received three doses of the diphtheria, tetanus and whooping cough.*** ▪ ***100 percent of surviving infants receiving first dose of measles containing vaccine (103.48% in 2015)).*** ▪ ***100% of districts presenting DTC3 present coverage >80% (100% in 2015).*** ▪ ***Difference of 0% in DTP3 coverage between lowest and highest wealth quintile.*** ▪ ***5% Drop-out rate between coverage of the first and third DTP dose (3.20% in 2015)*** ▪ *100% of children 12 to 23 months old are fully immunised*
Related Key Activities Indicators: ▪ *Percentage of ICC meetings held annually;* ▪ *Percentage of monitoring of the implementation of Gavi HSS activities carried out per year* ▪ *Proportion of structures that were the subject of internal control on the management of Gavi HSS resources.*	***Related Intermediate Results Indicators:*** ▪ *Rate of mobilisation of EPI funding* ▪ *Number of new vaccines introduced* ▪ *Percentage of structures that have a management score of at least 80%.*	
***Objective 2*: Improve the delivery of immunisation services by increasing the percentage of districts with a 100% fully immunised child rate from 55.5% to 90% through 2021.**		
Key Activities: ▪ *Support the semi-annual specific supervisions of the EPI at the DRS, Healthcare District and private healthcare facility levels from 2017 through 2021*	***Intermediate Results:*** ▪ *100% of structures that provide immunisation have a quality index of at least 80%*	***Immunisation Outcomes:*** ▪ ***100% of surviving children who received three doses of the diphtheria, tetanus and whooping***

▪ Conduct immunisation using advanced strategies in 990 Health and Social Promotion Centres (CSPS) in the 28 districts with low vaccine coverage and 7 new Healthcare Districts (gold panning and refugee sites, farming hamlets, border zones, markets, etc.) from 2017 through 2021 ▪ Conduct IEC/CCC sessions where the population of the 28 health districts with low performance and the 7 new districts regarding immunisation from 2017 through 2021.	▪ *100% of children from specific sites with immunisation (gold panning and refugee sites, cultural hamlets, border zones, contracts, etc.).* ▪ *Populations have good understanding of the importance of using immunisation services.* ▪ *The population in general and men in particular apply the instructions with regard to immunisation.* ▪ *100% of public healthcare structures offer routine immunisation of children.*	***cough.*** ▪ ***100 percent of surviving infants receiving first dose of measles containing vaccine (103.48% in 2015)).*** ▪ ***100% of districts presenting DTC3 present coverage >80% (100% in 2015).*** ▪ ***Difference of 0% in DTP3 coverage between lowest and highest wealth quintile.*** ▪ ***5% Drop-out rate between coverage of the first and third DTP dose (3.20% in 2015)*** *100% of children 12 to 23 months old are fully immunised*
Related Key Activities Indicators: ▪ *Percentage of specific EPI supervisions carried out;* ▪ *Percentage of Health and Social Promotion Centres that perform immunisation using advanced strategies in specific/difficult to access zones;* ▪ *Percentage of DRS equipped with approved freezers;* ▪ *Percentage of DS equipped with approved freezers;* ▪ *Percentage of DS equipped with approved refrigerators;* ▪ *Percentage of IEC/CCC sessions held.*	***Related Intermediate Results Indicators:*** ▪ *Percentage of children from specific sites that were immunised.* ▪ *Percentage of DRS, DS and CSPS that have sufficient storage* ▪ *Vaccine stockout rate at the DRS, DS, and CSPS level* ▪ *Proportion of men familiar with the importance of immunisation.*	
Objective 3: **Increase the routine immunisation data consistency index from 93.6% to 97% through the end of 2021;**		
Key Activities: ▪ *Conduct a semi-annual DQS at the level of the DRS and Healthcare Districts from 2017 through 2021* ▪ *Procure, install high-speed connection kits for the DRS, Healthcare Districts, DPV and the DSS for the entry of data into ENDOS (DHIS2) in 2017.* ▪ *Train 20 new agents from each district in filling out the SNIS tools in one 3-day session in 2017 and 2021*	***Intermediate Results:*** ▪ *100% of structures that provide immunisation have a quality index of at least 80%* ▪ *The completeness and promptness of immunisation data entered into ENDOS-BF are 100% and 95% respectively.*	***Immunisation Outcomes:*** ▪ ***100% of surviving children who received three doses of the diphtheria, tetanus and whooping cough.*** ▪ ***100 percent of surviving infants receiving first dose of measles containing vaccine (103.48% in***

Related Key Activities Indicators: ▪ *Percentage of DQS conducted per year;* ▪ *Percentage of structures that have operational connection kits;* ▪ *Percentage of agents trained on the National Health Information System*	***Related Intermediate Results Indicators:*** ▪ *proportion of structures having a quality score of at least 80%.* ▪ *completeness rate* ▪ *promptness rate*	***2015)).*** ▪ ***100% of districts presenting DTC3 present coverage >80% (100% in 2015).*** ▪ ***Difference of 0% in DTP3 coverage between lowest and highest wealth quintile.*** ▪ ***5% Drop-out rate between coverage of the first and third DTP dose (3.20% in 2015)*** ▪ *100% of children 12 to 23 months old are fully immunised*
Objective 4: **Strengthen the management of the supply chain for vaccines, consumables and logistics at all levels.**		
Key Activities: ▪ Procure 13 approved freezers for the Regional Health Directorates, 60 freezers, 70 approved VLS 400A refrigerators and 30 solar refrigerators for the Healthcare Districts and 177 approved solar/electric refrigerators, Model TCW 2043 SDD for the Health and Social Promotion Centres, in 2018 through 2021 ▪ Cover repairs to 10 cold rooms of the DPV and 13 regional cold rooms from 2017 through 2021 ▪ Each year, cover the control/inspection of EPI warehouses (central and regional) regarding good vaccine and supply management practices for 2017 to 2021	***Intermediate Results:*** ▪ *100% of DRS, Healthcare Districts and CSPS have sufficient storage.* ▪ *Vaccine stockout rate at the DRS, DS, and CSPS level* ▪ *100% of vaccines inspected comply with quality standards* ▪ *100% of storage capacity for vaccines at the central, regional and district level (positive cold chain) are covered.*	***Immunisation Outcomes:*** ▪ ***100% of surviving children who received three doses of the diphtheria, tetanus and whooping cough.*** ▪ ***100 percent of surviving infants receiving first dose of measles containing vaccine (103.48% in 2015)).*** ▪ ***100% of districts presenting DTC3 present coverage >80% (100% in 2015).*** ▪ ***Difference of 0% in DTP3 coverage between lowest and highest wealth quintile.*** ▪ ***5% Drop-out rate between coverage of the first and third DTP dose (3.20% in 2015)***
Related Key Activities Indicators: ▪ *Percentage of DRS equipped with approved freezers;* ▪ *Percentage of DS equipped with approved freezers;* ▪ *Percentage of DS equipped with approved*	***Related Intermediate Results Indicators:*** ▪ *Percentage of DRS, DS and CSPS that have sufficient storage* ▪ *Vaccine stockout rate at the DRS, DS, and CSPS level*	

refrigerators; ▪ *Percentage of regional and Healthcare District EPI warehouses inspected;* ▪ *Percentage of cold rooms that are the subject of a maintenance agreement.*	▪ *Percentage of inspected warehouses having a management score of at least 80%* ▪ *Vaccine stockout rate at healthcare facilities*	▪ *100% of children 12 to 23 months old are fully immunised.* ▪ *30-DTR temperature recorder heat alarms reduced by 50% and freeze alarms reduced by 90% in 2018, in comparison.* ▪ *All cold chain equipment used to store vaccines at the level of the DRS and Healthcare Districts were approved and protected against freezing.* *The number of unopened, unexpired vials discarded due to exposure to freezing or excess heat does not exceed 1% at the DRS and Healthcare Districts, and in any CSPS equipped with new cold chain equipment.*

IMPACT

Reduction of the rate of maternal and infant mortality

HYPOTHESES

- *Political commitment by the Government and technical and financial partners*
- *Compliance by the population*
- *Quality of information collected*
- *Collaboration with research centres*
- *Stable socio-political environment in the country*
- *Capacity to manage natural catastrophes*
- *Stability of healthcare personnel*
- *Mastery of targets*

15. Monitoring and Evaluation (M&E) (Maximum 2 pages)

Provide a description of how HSS grant performance will be monitored.

Monitoring of the grant is within the context of the National Health Development Plan described in Item No. 8.

Additionally, a committee was established to monitor and assess the implementation of the Gavi HSS grant It is charged with planning the activities of the proposal, monitoring the physical and financial performance of activities, playing the role of interface with Gavi, producing quarterly reports to be submitted to the HDSP steering committee, making proposals and/or recommendations for the successful implementation of activities.

The DGESS is the primary contact with the Gavi Secretariat for monitoring the implementation of the Gavi-HSS grant. It takes care of the coordination of activities of the Technical Directorates involved, the HDSP and implementation structures (DRS, Healthcare Districts). Focal points were appointed at the level of the DGESS, DPV and HDSP for monitoring and processing information relative to the grant.

The vaccine coverage survey and the in-depth review of the EPI that were planned and conducted under the direction of the DPV every 5 years allow assessment of vaccine coverage and equality. (Cf.: vaccine coverage reports and in-depth EPI review, attached).

This grant anticipates an internal mid-point assessment in the form of a review and a final external assessment. Costs related to these assessments are included in the proposal budget.

16. PBF Data verification option

Choose which data verification option to be used for calculating the performance payments.

Data verification option	Select ONE
Use of country administrative data	x
Use of WHO/ UNICEF estimates	
Use of surveys	

PART D: WORKPLAN, BUDGET AND GAP ANALYSIS

17. Detailed workplan, budget and gap analysis (Maximum 3 pages)

*Fill out **Mandatory Attachment No. 6**: Detailed workplan, budget and gap analysis via the country's Internet portal.*

Detailed instructions to fill in the budget template are available in the first worksheet of the Excel template.

*Once the budget template and financial gap analysis have been completed, provide a **budget and gap analysis narrative here.**.*

Financial data from filling out this form are summarised as follows:

- Funding requirements for health system strengthening in the context of the implementation of the NHDP are estimated at 7,293,449,076 US$ for the 2017-2021 period;

- Total funding related to HSS for the 2017-2021 period, all sources considered together, is estimated at 1,875,113,082 US$[2] ;
- The financial gap resulting from the funding requirements and total funding is 5,418,335,494 USD

The Gavi-HSS contribution which is estimated at 11,760,000 US$, will allow a reduction in this funding gap for the implementation of activities linked to immunisation for the 2017-2021 period.

This proposal is aligned in addition with the Global Fund HSS grant covering the period of 2015-2017. An exact status of the contribution by other partners is not available. However analysis of bottlenecks has allowed a gap to be filled for the period of 2017-2021. In addition, the country is in the process of preparing a national strategic plan for health system strengthening which in time will allow gaps to be determined after consideration of the contributions made by the various partners.
In addition to the foregoing response,it must be noted that the participation by partners in the country does not target specific geographic regions, but respects principles of alignment and the spirit of the Compact for implementation of the NHDP.

Pooled fund applicants *are not required to complete the workplan, budget and gap analysis template. Instead, specific information on the sector wide annual workplan and budget should be provided.*

18. Sustainability (Maximum 2 pages)

Describe how the government is going to ensure programmatic sustainability of the results achieved by the Gavi grant after its completion.

Prevention measures have a significant positive impact on the health condition of the population. Additionally, the government of Burkina Faso has committed itself to maintaining the gains earned in the EPI, including those of Gavi support to reinforce the healthcare system in conjunction with immunisation.

At the national level, the Government will ensure the sustainability of results obtained by placing an emphasis on hiring, training (ongoing and basic), healthcare personnel, the availability of vaccine products and funding of coordination structures and implementation. Thus, the annual contribution of credits to the Directorate of Prevention by Immunisation (DPV) and to the structures of the various levels for coordination and implementation of EPI services will be continued. In addition, the Burkina Faso government will make qualified agents available for the implementation of immunisation activities, as well as the payment of their salaries. Furthermore, the application of personnel regulations taking into consideration the package of activities specified for the various levels will allow better performance of these activities. The Burkina Faso Government will continue to ensure the consistency of registration in the secured loan finance act of at least one billion CFA francs per year for the procurement of vaccines and injection materials, provision of cold chain equipment and transportation, strengthening the capabilities of the health personnel, support for social mobilisation activities, mobile and advanced strategies, monitoring and supervision of EPI target diseases. These budget categories dedicated to immunisation are an addition guarantee of the sustainability of funding of immunisation activities. It will thus continue the construction/rehabilitation of basic healthcare facilities, excellence centres for the provision of immunisation services. Good maintenance of procured equipment will allow them to be sustainable, to be available to ensure the correct progress of activities at healthcare facilities. For the rest, lobbying of government decision-makers to regularly increase the funding allocated to the Expanded Programme on Immunisation will be carried out. Despite the increase in the contribution from the State for funding immunisation-related activities, the support from partners is still the most critical. The activities of the financial sustainability strategy will

[2] Announcement of partners is limited to 2020 instead of 2021.

focus on maintaining the current level of support from traditional partners or even their additional contribution. Similarly, in order to minimise the gap, the Government, through the Ministry of Health, will mobilise other potential partners as part of the bilateral cooperation. The involvement of NGOs and associations will be strengthened. The increase in contributions by partners to the mobilisation of new support for funding immunisation will take place via reinforcement of the involvement of the ICC in the monitoring of activities, performance values and the emergency of new needs on the part of the EPI, the integration of immunisation activities into new economic and technical cooperation frameworks and the strengthening of the EPI's place in the sectoral health strategy.

At the decentralised, distributed level, the Government, with the contribution of its development partners, will guarantee the allocation of credits to the Regional Directorates and the Healthcare Districts for training health agents, preventive maintenance and repairs to equipment, social mobilisation and monitoring of activities.

Thus, there is the responsibility of populations at health and social promotion centres through management committees that disburse their own funds and will contribute to covering recurring expenses related to immunisation activities, in particular the supply of gas for cold chain equipment, preventive maintenance, management of biomedical waste, fuel for advanced strategy, etc.

In the context of the complete decentralisation, territorial communities mobilise resources (human, physical and financial) to support the implementation of health activities, particularly those related to immunisation.

Immunisation is integrated with other activities of the Minimum Package of Activities of these CSPS. The Burkina Faso Government will continue to make its contribution for the introduction of new vaccines. This portion will gradually increase.

The coordination, monitoring, and control of activities will be covered at all levels; strengthening of technical capacities of service providers at all levels in programme management, planning, coordination, formative supervision and integrated monitoring; reduction in the vaccine wastage rates through strengthening the use of the open vial policy by agents in the field, the extension of mechanisms to encourage keeping personnel responsible for immunisation in their work position will contribute to ensuring the rationalisation of immunisation costs on the one hand and ensuring the quality of services on the other.

In addition, emphasis will be placed on the involvement of beneficiaries. This will involve intensifying the social mobilisation activities to increase the community participation in immunisation activities. This will involve support from the communities in activities for active search of unreached children, educating the community on the importance of immunisation and acceptance of new vaccines and reporting cases of program targeted diseases.

Lastly, actions will be taken for better recovery of receipts in the context of the performance of the Government budget and searching for alternative funding sources. They will undoubtedly allow strengthening of the available resources at the national level, therefore those allocated to health structures at various levels.

*Pooled fund **applicants** applicants are required to provide existing documentation regarding the issue of sustainability. List which documents have been provided and reference the relevant sections.*

PART E: IMPLEMENTATION AND RISK MITIGATION PROCEDURES.....

19. Implementation arrangements (Maximum 2 pages)

Describe the planned implementation arrangements

*Pooled fund applicants **are** required to provide documentation regarding the procedures for implementation of sectoral mechanisms, as applicable. List which documents have been provided and reference the relevant sections.*

Management mechanism	Description

Identify key implementing entities and their responsibilities.	In the implementation of this proposal, the structures of the Ministry of Civil Society will be held responsible based on the central, decentralised and operational levels. The General Secretariat of the Ministry of Health provides administrative oversight of implementation of the Gavi/HSS grant. Thus, the DGESS will be responsible for technical planning, monitoring and coordination via the Gavi monitoring committee implemented for this purpose (Cf. Decree). In addition, they shall serve as the focal point between the Gavi Secretariat and the Ministry of Health. It will issue technical opinions and provide instructions for the proper implementation of the proposal. With regard to the DPV, it will coordinate, monitor and evaluate activities related to immunisation (resupply of districts and DRS with vaccines and supplies, management and monitoring of immunisation data quality, availability and maintenance of cold chain equipment, training, supervision, waste management, epidemiological surveillance of EPI targeted diseases, etc.). With regard to the DGPML, it is charged with the implementation of the activities relative to pharmacovigilance, AEFI management and securing supplies and health products. The Health Development Support Programme (HDSP) is responsible for financial management of the subsidy under the technical responsibility of the DGESS. (Cf. Section 22). The HDSP steering committee will approve the activity and financial reports on the implementation of the proposal.
Governance and oversight arrangements	The National Monitoring Committee of the HDSP (CS/NHDP) will provide Coordination, monitoring and assessment as well as control of the implementation of the grant. It is chaired by the Minister of Public Health.
Mechanisms which will ensure coordination among the implementing entities.	The coordination mechanism will be the same as the one from the 2011-2020 NHDP. It includes: (i) The National Monitoring Committee of the NHDP (CS/NHDP) and subject-specific oversight committees of the NHDP; (ii) at the regional level the Regional Oversight Committee of the NHDP; and (iii) the Health District Council (CSD) at the peripheral level; Coordination of the implementing entities is provided through semi-annual meetings of the National Oversight Committee of the NHDP during which a sectoral performance report including the implementation of the subsidy is reviewed. This report takes into consideration the contributory reports of the CRS including the CSD and subject-specific oversight committees of the NHDP. Furthermore, decisions and specific instructions regarding immunisation are taken by the ICC. The instructions and decisions made translate into planning directives prepared by the DGESS, through central, intermediate and operational structures for the preparation of their annual action plans. A multi-disciplinary oversight committee established by decree of the Minister of Health provides ongoing oversight for implementation. Placed under the responsibility of the DGESS, this committee meets quarterly or in special session as necessary. It is charged with preparing a physical and financial inventory of the implementation of activities, identifying difficulties encountered and preparing suggestions for improvement.

Financial resources from the grant proceeds that will be allocated to grant management and implementation.	5% of the grant amount will be dedicated to management at the HDSP level.
The role of development partners in supporting the country in grant implementation.	The development partners participate in the decision-making instances in the context of planning, oversight, assessment and control of the implementation of the Gavi/HSS grant.

20. 20. Involvement of Civil Society Organisations (CSOs) (Maximum 2 pages)

Describe how CSOs will be involved in the implementation of the HSS grant.

In Burkina Faso, the contribution of Non-governmental Organisations (NGOs) and associations in fields such as Reproductive Health, the fight against HIV/AIDS, tuberculosis and malaria, nutrition, etc. are deemed to be decisive to boost indicators. Technical and financial partners such as Gavi and the Global Fund give a significant place to civil society activities in their approach. In contrast, the commitment of NGOs and associations to strengthening the health system together with immunisation activities are still reserved as noted by the 2016-2020 cMYP and the Gavi HSS2 Review. This observation was also made by the Gavi Secretariat and its CSO district. To remedy this, Gavi supported the implementation of civil society platforms to support immunisation in various countries, including Burkina Faso. So since 2012 this support for civil society via the permanent Secretariat of NGOs (SPONG) allowed civil society participants to be sensitised regarding the interest in promoting immunisation and the increased commitment to strengthening the health system. These advocacy/awareness actions have led to the establishment of the national platform of NGOs and associations supporting immunisation and vaccination (PNOSV-BF) which covers the entire territory with 13 regional focal points and a national coordinating committee comprising six organisations, the coordination of which is carried out by SPONG. This platform poorly covered (with regard to the modestness of resources) the various regions of the country in terms of IEC activities. The outcome of the process started in 2012 is the effective consideration of specific activities of civil society in HSS activities funded by Gavi as is the case for other partnerships. PNOSV-BF will focus on the EPI, supplementing other funding from the Global Fund targeting HIV/AIDS, tuberculosis and malaria.
In the context of this application, which has had significant participation from civil society through PNOSV-BF, the issue will be to strengthen the dynamic already in progress for greater involvement of civil society in HSS, in particular for activities related to immunisation.
The involvement of civil society will follow the axes specified below:

- mobilisation of communities to increase demand for immunisation or health care for children, through community communication for immunisation (educational chats, outdoor theatres, video projections, etc.), searching for immunisation dropouts;
- contribution of technical assistance to the design and implementation of the HSS, particular activities related to immunisation;
- independent monitoring of immunisation and HSS programmes, in particular the management of subsidies and the quality of immunisation activities (logistics, cold chain, indicators, data quality, equality, etc.);
- lobbying in support of immunisation-related issues;
- performance of operational research;
- etc.

The activities included in this application are described above. These activities are:

1. Activity 1.1: Cover the operation of a programme team within the National Platform of

NGOs/Associations in support of vaccination and immunisation for better involvement in the implementation of Gavi HSS activities from 2017 through 2021

2. Activity 1.11: Organise one (1) annual meeting for the dialogue framework involving civil society, the private healthcare sector and the Ministry of Health in the context of strengthening of immunisation activities from 2017 through 2021
3. Activity 2.11: Conduct annual advocacy sessions in support of immunisation with religious, traditional and community leaders from 28 health districts with poor performance in 2017 and 2020.
4. Activity 2.12: Train 13 members of the national platform of NGOs and associations in support of immunisation (PNOSV) in immunisation-related communication for 3 days in 2017 and 2019
5. Activity 2.13: Conduct IEC/CCC sessions where the population of the 28 health districts with low performance and the 7 new districts regarding immunisation from 2017 through 2021.
6. Activity 3.4: Train 20 members of NGOs/Associations and 10 agents from private facilities on the SNIS in one 5-day session in 2018 and 2019
7. Activity 4.9: Cover independent oversight of vaccine and supply availability at healthcare facilities.

These activities will allow:

- an increase in demand for immunisation;
- strengthening of community participation;
- contribution to better governance of the EPI;
- strengthening the Government-Civil Society dialogue regarding HSS related to immunisation;*
- etc.

For the successful contribution of civil society and by drawing a lesson from other experiences, **the selected mechanism for the management of funds for civil society in the context of this application will be the subject of a contract between Gavi and the platform coordination team, i.e. the Permanent Secretary of NGOs (SPONG) which is the legal endorsement of the platform.** Funds returned to civil society will primarily consist of funds budgeted for activities selected in the context of this application.
The efficacy of civil society involvement is dependent on this organisation, which complies with the reality in Burkina Faso and that is not contrary to the Gavi guidelines for preparation of the application.

Pooled fund applicants are required to summarise the role of CSOs in the implementation of the sector wide programme.

21. Risks and mitigation measures *(Maximum 2 pages)*

If available, provide Attachment No. 35: Risk assessment in the health sector. If such an assessment is not available, provide an analysis of the risks of not achieving the objectives in this application.

Description of risk	*PROBABILITY*[3]	*IMPACT*[4]	*Mitigation Measures*
Objective 1: Strengthen coordination, monitoring and assessment of the health system from 2017 through 2021			
Institutional Risks			
Insufficient coordination of interventions and cooperation frameworks	***Low***	***High***	*A committee was created to monitor the implementation of Gavi HSS activities. This committee has sufficient human resources and skills capable of managing and analysing the flows of data. The standardised collection tools are also available and mastered by all members. The infrastructure (transport resources and computer tools) are also available to monitor the programme.*
Socio-political and economic instability on the national and international level.	***Average***	***High***	*Consideration of specific contextual areas*
Fiduciary Risks			
Fraud and corruption risk that may negatively influence the proposal's implementation	***Low***	***High***	*Effective application of regulatory texts in this regard, strengthening of the legal framework and control systems*
Operational Risks			
Insufficiency in planning and monitoring of activities at the level of healthcare facilities	***Low***	***High***	*Strengthening of planning and monitoring activities at every level.*
Inequitable distribution of health care personnel;	***Average***	***Average***	*Strengthening of the regional directorates and health personnel facilities; building loyalty of workforce thanks to better organisation of personnel, granting of indemnity by residential zone, improvement in working conditions and better management policies.*
Programmatic and Performance Risks			
Inadequate monitoring-assessment and coordination within the sector.	***Low***	***High***	*Allocate coordination activities and monitoring and evaluation of meetings linked to immunisation.*
Objective 2: Improve the delivery of immunisation services by increasing the percentage of districts with a 100% fully immunised child rate from 55.5% to 90% through 2021.			
Institutional Risks			
Insufficient organisation of immunisation services at the operational level	**Average**	**High**	Develop innovative strategies for immunisations in healthcare facilities and at villages
Insufficient storage capacity for vaccines and supplies.	**Average**	**High**	Strengthening of capacities for storage of vaccines and other supplies
Insufficient 2- and 4-wheeled vehicles.	**Average**	**High**	Contribution by healthcare facilities of wheeled vehicles for immunisation activities
Insufficiency of health human resources and poor distribution of existing personnel	**Average**	**High**	Continued recruitment of personnel by regional stations; loyalty of healthcare personnel via better workforce organisation, granting of indemnification by residential zone, improvement of the working conditions and for

[3] *high / medium / low*
[4] *(high, medium, low)*

			better management policies implementation of measures for facilitation[5] and establishment of a more transparent agent notation system, based on performance
Socio-political and economic instability on the national and international level.	**Average**	**High**	Consideration of specific contextual areas
Poor cooperation with Civil Society Organisations and the private sector	***Average***	***High***	*collaboration with the various structures related to communication activities must be strengthened to achieve better results; Standardisation of interventions by CSO, private sector in the field of immunisation communication.*
Fiduciary Risks:			
Insufficient funding allocated to communication at all levels, particularly related to the routine EPI.	***Average***	***High***	*Allocate the resulting funds to communication activities for immunisation.* *Local mobilisation of funds and of innovative funds to support immunisation activities.*
Delay in allocating funds	**Average**	**High**	Annual operational planning of activities transmitted over time to Gavi
Poor ability to absorb or disburse funds	**Average**	**High**	Simplification of contract approval procedures Implementation of a monitoring and assessment procedure Strengthening of the skills of agents responsible for management
Operational Risks:			
Weakness of accessibility of populations to immunisation sites	***Average***	***Average***	Multiplication of immunisation sites using advanced strategies
Poor involvement of men in immunisation services	***Average***	***Average***	*Intensification of proximity communication actions* *The involvement of government, political, traditional, religious authorities and other participants with competence in the field of communication in order to encourage compliance by the population with routine immunisation activities.*
Socio-cultural burdens	***Average***	***High***	*- Systematic intersectorality* *- Strengthening of awareness and advocacy activities in relation to opinion leaders,* *Involvement of Civil Society Organisations in awareness and advocacy activities in relation to opinion leaders,*
Poor availability of ASBC	***Average***	***High***	Strengthening ASBC capabilities; Motivation of ASBC
Programmatic and Performance Risks			
Insufficient planning, monitoring and assessment at all levels;	***Average***	***High***	Strengthening of capacities; strengthening of specific supervisions and monitoring and assessment system
Poor quality of data	***Average***	***High***	*Capacity building in data management. 6.* *Quality control of data, validation of data*
Failure to attain results vis-à-vis anticipated targets	***Average***	***High***	*Regular monitoring of interventions* *Improvement of access of populations to immunisation services*
Failure to control target populations	***Average***	***Average***	*Regular performance of projections for the target population*
Failure to attain results vis-à-vis anticipated targets	***Average***	***Average***	*Strengthen skills of participants and equip them with projection and coordination equipment. Regular monitoring of communication interventions.* *Improvement of the accessibility of populations to immunisation communication services*
Other Risks			

[5] (Decree No. 2005-570/PRES/PM/MFB/MFPRE of 24 November 2005 amending Decree No. 2005-010/PRES/PM/MFB/MFPRE of 24 January 2005 regarding the indemnification system applicable to public agents of the Government, the availability of a career plan that allows advancement and promotion by adopting organisational texts for specific jobs of the Ministry of Health, improvement of work conditions (facilities, materials, comfort).

Poor commitment by all participants (healthcare professionals, related sectors, civil society including NGOs and associations, the private sector, professional orders, local municipalities and development partners) to working to attain the established objectives.	***Low***	***High***	*Implementation of the participatory approach with involvement of all stakeholders at various levels of the health system.* *Better collaboration with stakeholders will be established to present them the activities of the proposal, in order to get them to fully enjoy an accompanying role.*
Institutional Risks			
Objective 3: Increase the routine immunisation data consistency index from 93.6% to 97% through the end of 2021;			
Institutional Risks			
Insufficient data management in public and private structures	***Average***	***High***	*Strengthening of capacities for data management; Availability of data collection media; Availability of a high-speed connection in healthcare districts, in DRS and at the central level.* *Gradual development of ENDOS in private care structures*
Fiduciary Risks			
Delay in allocating funds	***Average***	***High***	*The organisational structure of funds (HDSP) is well organised, with documented roles and responsibilities and sufficient separation of the tasks described in the procedures manual. In addition, the structure has sufficient human resources with the skills and resources required for financial management. The cashflow and budget management system are well documented and ensure the absence of duplication of expenses. The financial statements of the organisation and its sub-beneficiaries are audited by an independent auditor, according to standard auditing principles.*
Operational Risks			
Poor qualify of data collected	***Average***	***High***	*Conduct data quality audits by performing Data Quality Self Assessments (DQS) and the Lot Quality Assurance Sampling (LQAS).* *Quarterly data validation meetings at the district level*
Programmatic and Performance Risks			
Poor completeness in data entry at the district level	***Average***	***High***	*Acquire and make available a high-speed connection in the health districts;* *Strengthening of available computer equipment*
Objective 4: Strengthen the management of the supply chain for vaccines, consumables and logistics at all levels.			
Institutional Risks			
Significant insufficiency of EPI logistics	***Average***	***High***	*Preparation and implementation of the vehicle logistics amortisation plan* *Completion and implementation of the maintenance plan for cold chain and transport equipment*
Fiduciary Risks			
Insufficient fiduciary efficiency	***Low***	***High***	*Guaranteed procedures (checks, drafts and transfers) will be prioritised and internal audits will be intensified.*
Losses due to contracts and the macroeconomic context	***Low***	***Low***	*Planning and budgeting took inflation into consideration in its forecasts*
Operational Risks			
Poor quality of procured equipment	***Average***	***High***	*The procurement of equipment and material approved via a guaranteed United Nations procurement system via Unicef.*
Insufficient monitoring and analysis of vaccine storage	***Average***	***High***	*Continuous temperature monitoring devices (30-DTR) will be installed,*

temperature monitoring data			*which will continuously monitor temperatures and technical visits after installation/rehabilitation of equipment for Cold Chain equipment will be conducted.* *Regular external and internal monitoring;* *Regular analysis of monitoring data;*
Insufficient distribution and installation of refrigerators	***Low***	***High***	*Ensure compliance with the planned distribution* *Quality assurance of equipment installed via technical inspection by a qualified national technician-engineer (30 days after installation) with recording of 30+ days of temperature data from 30-DTR recording devices*
Poor repair quality for cold rooms:			*Installation of centralised, networked temperature monitoring systems, cartography of temperature distribution within cold rooms after rehabilitation will be carried out.*
Programmatic and Performance Risks:			
Inequitable distribution of logistics	***Average***	***High***	*The diagram for deployment of logistics will be respected among the structures targeted by this proposal.*
Insufficient dry storage space for equipment proposed in the event of delays during deployment in the field.	***Low***	***High***	*Other* warehouses will be requisitioned from the Ministry of Health (CAMEG and other structures) during the period for receipt of equipment for secure storage while awaiting distribution Early and ongoing distribution, waybills signed for each site by equipment recipients, etc.
Stockouts of vaccines and consumables	***Low***	***High***	Training of participants will be by the EPI at various levels and it will emphasise the management of supplies and vaccines Orders will be advanced to prevent stockouts.

22. Financial management and resupply

Describe the proposed budgetary and financial management mechanisms for the grant

The funds mobilised in the context of this application will be managed according to the current procedures of the Health Development Support Program (HDSP). The procedures for pooled funds, decision-making, disbursement mechanisms, production of activity and financial reports and the internal controls of the HDSP will be used.

Management will be decentralised and performance-oriented. The objective is to encourage stakeholders to develop a culture of results instead of a focus on the performance of scheduled activities.

The procurement and resupply mechanisms will espouse the HDSP procedures. For the procurement of approved materials or designated marks, coordination between the HDSP and Unicef is indicated.

Regional accountants based in the DRS will be charged with monitoring and controlling the use of funds and compliance with procedures every month. The HDSP Management Unit, via the internal audit unit, will carry out controls and audits in each structure at least once per year. Furthermore, independent auditors will conduct global financial audits once per year.

Describe the main constraints in the health sector's budgetary and financial management system.

Health funding is in the red. The search for additional funding (innovative funds, municipalities, partners, etc.) for health is deemed a necessity.

The sustainability of funding for healthcare activities is an ongoing concern for the Government. The implementation of a financial management system to provide clear, results-oriented guidelines may

allow effective mobilisation of financial resources for the Ministry of Health.	
Complete the Budgetary and Financial Management Arrangements Data Sheet (below) for each organisation that will directly receive HSS grant finance from Gavi.	
*Provide **Mandatory Attachment No. 7**: Detailed two-year Procurement Plan*	
Pooled fund applicants are required to provide relevant documents for financial management and procurement under the pooled funding arrangement.	
Budgetary and Financial Management Arrangements Data Sheet	
Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).	
1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	**Mr. OUEDRAOGO Abdoul Karim** (HDSP Coordinator) Tel.: (00226) 25 30 88 46 / + 226 70 20 01 17 Email: pads@fasonet.bf/ ouedabk@yahoo.fr 03 BP : 7062 Ouagadougou 03
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
3. If YES: • Please state the name of the grant, years and grant amount.	GAVI/RSS1 /2008-2010 : **4,978,773 USD** GAVI/RSS1 /2013-2015 : **5,228,714 US$** GF/HSS: **17,347,022 Euros**
• For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance.	In the context of 2014 global audits, the primary conclusions were as follows: - There was no violation or contravention of the law, decrees or regulations, no warning, notification or notice of official entities, the effect of which for the HDSP is allegedly such that these facts must be specified in a memo attached to the accounts; - There was no irregularity or misappropriation committed with the HDSP that could significantly question the efficacy of the internal auditing system, or that could have a significant effect on the accounts or their presentation.
• For on-going Grants of Gavi and other Development Partners: Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	In 2015, the primary problems raised by the Gavi HSS2 review were: - delays in the acquisition of logistics resources; - the relatively long time between the end of an application and the submission of the new application;

	- under-estimation of funds with regard to certain significant activities likely to boost and maintain a good quality level of EPI services. - late disbursement of funds benefiting healthcare districts leading them to carry out activities in very short time frames. - lack of flexibility of procedures, not allowing funds disbursement thresholds based on specific needs for certain interventions.
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	A monitoring committee was put in place for the implementation of the grant (Decree No. 2015-1593/MS/CAB of 28 December 2015). The committee operates under the responsibility of the Director of Monitoring, Evaluation and Capitalisation (DSEC) The DSEC is a technical department of the DGESS. Members of the monitoring committee come from the DGESS, DGS, DPV, DAF HDSP and resource personnel. The committee may call upon any individual or legal entity as necessary. A coordinator is charged with maintaining files, generating committee reports, etc. The monitoring committee is charged with oversight of the grant. The committee meets four times per year to review visit reports and refines the implementation status of the grant.
5. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	Planning is carried out under the responsibility of the General Director of Research and Sectoral Statistics (DGESS) in cooperation with the HDSP coordinator and the Director of prevention by immunisation (DPV).
6. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	The planning process is that recommended in the NHDP. It is annual and considers all axes of the NHDP. The annual Gavi HSS budget is approved by the HDSP steering committee, chaired by the Secretary General of the Ministry of Health.
7. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement? (i.e. the currency of the account, movement of	Funds will be transferred into the account opened from the common pool (in XOF) where

funds to the programme). List the titles of signatories authorised to make payment transactions and requests for further disbursements of funds.	funds from the other partners have already been transferred. The titles of the authorised signatories are: - HDSP Coordinator - Chief of the HDSP Financial and Accounting Department
9. Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	Gavi HSS funds will be transferred to an account opened with a central bank. The same management procedures will be used for this funding dedicated to activities to strengthen the health system, linked to immunisation.
10. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- “pooled account”)?	This account will also be supplied with funds transferred by other partners from the common pool, i.e.: United Nations Population Fund (UNPF), Gavi funds, United Nations Children's Fund (Unicef), Funds from the French Development Agency (AFD). For requirements for monitoring activities related to Gavi funding, the physical and financial reporting will appear in the same report produced by the HDSP management unit, but separately.
11. Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc. If YES, please describe how fund transfers will be executed and controlled. Please in particular state at what time of year (month/ quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner.	YES

Mechanism for transferring Gavi HSS grant funds from the central to the peripheral level
The funding procedure selected for the implementation of the HDSP is decentralised performance-based management. The objective is to encourage stakeholders to develop a culture of results instead of a focus on the performance of scheduled activities. The transfer of Gavi funds to peripheral structures will comply with the following rules:

- HDSP wishes to receive Gavi HSS funds no later than the end of September of each year (n-1)
- distribution of funds in accordance with the activities selected in the proposal and according to a key and criteria defined in advance;
- communication of the loans granted to each structure by October;
- preparation of an action plan;
- preparation and execution of agreements between the beneficiary structures and the HDSP Steering Committee;
- preparation of an overall action plan incorporating all funding sources with a consolidated budget that includes the needs expressed by first-level healthcare facilities;
- review and funding of action plans by the Steering Committee;
- allocation of funds by drawing in two semi-annual instalments to the existing HDSP commercial bank accounts with each structure, the first instalment of which shall be made by January;
- regional accountants and the internal audit service of the HDSP will provide for the control of the allocated funds.

Mechanism (and responsibility) for budget use and approval
Gavi funds shall be used in accordance with the existing decentralised management procedures manual (Cf. manual attached).

Mechanism for transferring Gavi HSS grant funds through commercial accounts
Pursuant to the procedures manual, funds will be disbursed based on the activities selected in the agreements and the detailed budget.

Procurement	
12. What procurement system will be used for the Gavi-HSS Program? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	The goods and services procurement system will be based on the general regulation governing public contracts. In addition, procurement and resupply mechanisms will comply with the management procedures put in place in the context of the HDSP implementation framework. For the procurement of approved materials or designated marks, coordination between the HDSP and Unicef is indicated. The management procedures manual specifies the grouping of goods and services of the same type for the approval of contracts by the Management Unit on the one hand to ensure compliance with current regulations in Burkina Faso, and on the other hand to encourage economies of scale. Acquisitions of goods and services in the context of the HDSP shall be carried out in accordance with the general regulation governing public contracts and delegation of public service in force in Burkina Faso. In addition to the regulatory texts, standard competitive documents were prepared by the competent units of the Ministry responsible for Finance, the use of which is mandatory for any individual or legal entity charged with approving

	contracts funded by public pools of funds. Thus, there is: - a standard call for bids document for the approval of common services and supply contracts; - a standard call for bids document for the approval of contracts for works (particularly civil engineering works); - a standard document for consultant selection. All of these standard documents were deemed to be acceptable by the community of sponsors participating in the healthcare area in Burkina Faso. The rules published in these texts are based on the principles of the correct use of funds, free access to public ordering, equality of treatment of bidders and transparency in the procedures for the approval and performance of contracts.
13. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Approved equipment or designated brands and vaccines will be acquired through the Unicef system
14. What is the staffing arrangement of the organisation in procurement?	Agreement protocols are signed by the supplier partners and the Ministry of Health. These protocols take into account the complementarity of various stakeholders.
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES The public contracts regulation allowed the establishment of a Public Order Regulation Authority (ARCOP) which is charged with: - settling litigation and disagreements arising from the approval or performance of contracts entered into by the national government; - reviewing complaints by bidders participating in competitive bidding processes; - reconciling parties to litigation or disagreements arising from the approval or performance of contracts entered into by the national government. In the latter case, it may recommend rescission of the contract to the competent agency.
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES Conflicts that arise in the context of contract approval are submitted to ARCOP and that generates an enforceable conciliation report or a non-conciliation report that is a necessary prerequisite to any legal action.

Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	Requests for quotes, calls for bids, price requests are normal procedures that are generally used. In certain cases, according to the agreements, funds may be transferred directly to the procurement structure.
19. What procurement system will be used for the Gavi-HSS Programme? (e.g. Is there a specific accounting software package or a manual accounting system?)	The accounting system used is the system currently in force in the country. The roles, responsibilities and duties are described in the procedures manual. In addition, the HDSP structure has sufficient human resources with the skills and experience required for financial management. There is also an appropriate accounting management software package capable of generating the statutory reports for the organisation (TOM2PRO). The cashflow and budget management system are well documented and ensure the absence of duplication of expenses. The financial statements of the organisation and its sub-beneficiaries are audited by an independent auditor, according to standard auditing principles.
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Status reports are generated every six months. At the end of the year, a consolidated report is generated and is used as the annual report. The reports are first modified by the HDSP steering committee, the monitoring/assessment entities of the NHDP, the TFP, MINEFID, NGOs, etc. After being modified, the report will be sent to the various partners participating in the HDSP funds management.

Internal control and internal audit	
21. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES
22. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	YES The procedures manual specifies measures to reduce risks and the HDSP has an operational internal auditing department. In addition, the AGF exercises control that prevents abuse and fraud. The HDSP is currently preparing an internal audit manual based on mapping of the risks.
23. Is there a functioning Audit Committee to follow up on the implementation of internal	YES

audit recommendations?	
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[6]	YES Regional accountants in the Regional Health Directorates are charged with monitoring and controlling the use of funds and compliance with procedures every month. The HDSP Management Unit, via the internal audit unit, will carry out audits in each structure at least once per year. In addition, independent auditors carry out global financial audits (encompassing all funding sources) in each structure once per year and the later are returned to the local level and on the national level with all the participants.
25. Who is responsible for the implementation of audit recommendations?	The Secretary General of the Ministry of Health, Chair of the HDSP Steering Committee, is responsible for the implementation of the audit recommendations.

Budget by objective

Objective	Cost in Central African Francs	Cost in US$	%
Objective 1: Strengthen coordination, monitoring and assessment of the health system from 2017 through 2021	1,178,908,542	1,964,848	16.7%
Objective 2: Improve the delivery of immunisation services by increasing the percentage of districts with a 100% fully immunised child rate from 55.5% to 90% through 2021.	2,987,796,078	4,979,660	42.3%
Objective 3: Increase the routine immunisation data consistency index from 93.6% to 97% through the end of 2021;	896,815,219	1,494,692	12.7%
Objective 4: Strengthen the management of the supply chain for vaccines, consumables and logistics at all levels.	1,992,480,980	3,320,802	28.2%

[6] If the annual external audit is planned to be performed by an independent private audit firm, an appropriate audit fee needs to be included in the budget.

Total	**7,056,000,819**	**11,760,001**	**100%**

Budget by objective and by activity

Objective / Activity	Total Cost CFA francs	2017	2018	2019	2020	2021
Objective 1: Strengthen coordination, monitoring and assessment of the health system from 2017 through 2021	**1,178,908,542**	**125,658,399**	**253,922,956**	**230,432,832**	**277,009,746**	**291,884,609**
Activity 1.1: Cover the operation of a programme team within the National Platform of NGOs/Associations in support of vaccination and immunisation for better involvement in the implementation of Gavi HSS activities from 2017 through 2021	81,579,395	9,555,933	18,005,866	18,005,866	18,005,866	18,005,866
Activity 1.2: Hold quarterly ICC meetings from 2017 through 2021	1,980,000	220,000	440,000	440,000	440,000	440,000
Activity 1.3: Hold quarterly TAG-EPI meetings from 2017 through 2021	5,400,000	600,000	1,200,000	1,200,000	1,200,000	1,200,000
Activity 1.4: Support the operation of the technical monitoring and assessment committee for implementation of the grant from 2017 through 2021	32,363,503	5,765,072	6,625,072	6,617,072	6,677,787	6,678,502
Activity 1.5: Support the operation of the grant management office (HDSP) from 2017 through 2021	148,650,000	20,010,000	32,160,000	32,160,000	32,160,000	32,160,000
Activity 1.6: Train 2 members of the HDSP Management Unit and 23 participants from the central and regional levels in results-oriented planning in Ouqgadougou, in 2020	15,921,536	-			15,921,536	
Activity 1.7: Contribute to the expenses for 3 agents hired (two accountants and one internal auditor) for Management Unit-HDSP from 2017 through 2021	48,600,000	5,400,000	10,800,000	10,800,000	10,800,000	10,800,000
Activity 1.8: Train 2 members of the Technical Committee in monitoring and assessment of projects and programs at CESAG in Dakar in 2017 and 2018	12,440,000	6,220,000	6,220,000	-	-	-
Activity 1.9: Conduct an internal mid-term assessment of the proposal in 2019	17,262,125		17,262,125			
Activity 1.10: Organise a final external evaluation of the	32,245,460					32,245,460

Objective / Activity	Total Cost CFA francs	2017	2018	2019	2020	2021
proposal in 2021						
Activity 1.11: Organise one (1) annual meeting for the dialogue framework involving civil society, the private healthcare sector and the Ministry of Health in the context of strengthening of immunisation activities from 2017 through 2021	9,841,900	1,968,380	1,968,380	1,968,380	1,968,380	1,968,380
Activity 1.12: Conduct quarterly visits to monitor implementation of Gavi HSS activities from 2017 to 2021	214,878,456	23,875,384	47,750,768	47,750,768	47,750,768	47,750,768
Activity 1.13: Support inspection and internal audits for the management of Gavi-HSS funds from 2017 through 2021	48,438,072	9,687,614	9,687,614	9,687,614	9,687,614	9,687,614
Activity 1.14: Support the funding sessions for annual action plans for structures of the Ministry of Health from 2017 through 2021	101,539,680	20,307,936	20,307,936	20,307,936	20,307,936	20,307,936
Activity 1.15: Conduct an independent survey by civil society regarding immunisation in the field in 2020	30,594,663				30,594,663	
Activity 1.16: Contribute to the financial audit expenses for the project for 2018 through 2021	80,000,000	-	20,000,000	20,000,000	20,000,000	20,000,000
Activity 1.17: Cover the production of periodic reports on the Gavi HSS grant from 2017 through 2021	17,550,000	1,950,000	3,900,000	3,900,000	3,900,000	3,900,000
Activity 1.18: Prepare the next application (Gavi-HSS 4) in 2021	46,543,924					46,543,924
Activity 1.19: Support the semi-annual integrated supervisions in the 70 Healthcare Districts from 2017 through 2021	172,782,720	19,198,080	38,396,160	38,396,160	38,396,160	38,396,160
Activity 1.20: Organise a meeting of Gavi-HSS focal points expanded to the Technical and Financial Partners every 2 months from 2017 to 2021	8,100,000	900,000	1,800,000	1,800,000	1,800,000	1,800,000
Activity 1.21: Support the regions and the Healthcare Districts in the preparation of results-oriented action plans integrating immunisation from 2018 through 2020	52,197,108	-	17,399,036	17,399,036	17,399,036	-
Objective 2: Improve the delivery of immunisation services by increasing the percentage of districts with a fully	**2,987,796,078**	**661,802,053**	**522,703,268**	**811,835,062**	**555,584,407**	**435,871,288**

Objective / Activity	Total Cost CFA francs	2017	2018	2019	2020	2021
immunised child rate through 2021 from 55.5% to 90%;						
Activity 2.1: Support the semi-annual specific supervisions of the EPI at the DRS, Healthcare District and private healthcare facility levels from 2017 through 2021	769,592,214	85,510,246	171,020,492	171,020,492	171,020,492	171,020,492
Activity 2.2: Conduct immunisation using advanced strategies in 990 Health and Social Promotion Centres (CSPS) in the 28 districts with low vaccine coverage and 7 new Healthcare Districts (gold panning and refugee sites, farming hamlets, border zones, markets, etc.) from 2017 through 2021	677,749,481	75,305,498	150,610,996	150,610,996	150,610,996	150,610,996
Activity 2.3: Carry out a monthly visit to inspect the effectiveness of advanced immunisation strategy in 2 villages in each of the 70 Health Districts by the ECD, from 2017 through 2021	255,150,000	28,350,000	56,700,000	56,700,000	56,700,000	56,700,000
Activity 2.4: Organise quarterly meeting of the national oversight commission and the oversight committee on vaccines and other biological products in 2018 and 2019	16,907,808		8,453,904	8,453,904		
Activity 2.5: Organise additional research missions for serious AEFI cases from 2017 through 2021	15,816,600	1,757,400	3,514,800	3,514,800	3,514,800	3,514,800
Activity 2.6: Organise 3, 5-day sessions for training EPI and CISSE supervisors from the DRS and Healthcare Districts in EPI management in 2017 and in 2020	93,847,238	55,509,119			38,338,119	
Activity 2.7: Organise 70, 5-day sessions for training health agents in EPI management in 2017 and in 2019.	696,142,580	344,058,790		352,083,790		
Activity 2.8: Organise the training of a pool of 10 participants responsible for immunisation during the mid-level management course on the EPI (MLM/EPI) in Burkina Faso, in 2018.	8,378,076		8,378,076			
Activity 2.9: Procure 8 supervision vehicles (2 station wagons and 6 extended cab pick-up trucks) for the DPV (2), the Healthcare Districts (5) and civil society (1) in 2018 and 2020	140,000,000		70,000,000		70,000,000	
Activity 2.10: Equip 16 training schools, 6 of which are public	13,096,080			13,096,080		

Objective / Activity	Total Cost CFA francs	2017	2018	2019	2020	2021
and 10 of which are private, with instructional materials in 2019						
Activity 2.11: Conduct 2 lobbying sessions in support of immunisation with religious leaders, traditional and community leaders from 28 healthcare districts with low performance and 7 new Healthcare districts in 2017 and 2020	22,750,000	11,375,000			11,375,000	
Activity 2.12: Train 13 members of the national platform of NGOs and associations in support of immunisation (PNOSV) in immunisation-related communication for 3 days in 2017 and 2019	4,741,000	2,411,000	-	2,330,000	-	-
Activity 2.13: Conduct IEC/CCC sessions where the population of the 28 health districts with low performance and the 7 new districts regarding immunisation from 2017 through 2021.	273,625,000	57,525,000	54,025,000	54,025,000	54,025,000	54,025,000
Objective 3: Increase the routine immunisation data consistency index from 93.6% to 97% through the end of 2021;	**896,815,219**	**247,047,710**	**120,090,012**	**160,429,884**	**249,157,600**	**120,090,012**
Activity 3.1: Conduct a semi-annual DQS at the level of the DRS and Healthcare Districts from 2017 through 2021	497,880,054	55,320,006	110,640,012	110,640,012	110,640,012	110,640,012
Activity 3.2: Cover the reproduction of media and tools for data collection for the SNIS and the EPI at the level of the healthcare districts in 2017 and 2019	70,000,000	35,000,000	-	35,000,000	-	-
Activity 3.3: Procure, install high-speed connection kits and cover the subscription fees for the DRS, Healthcare Districts, DPV and the DSS for the entry of data into ENDOS (DHIS2) from 2017 through 2021	70,799,988	32,999,988	9,450,000	9,450,000	9,450,000	9,450,000
Activity 3.4: Train 15 members of NGOs/Associations and 15 agents from private facilities on the SNIS in one 5-day session in 2019 and 2020	10,679,744	-	-	5,339,872	5,339,872	-
Activity 3.5: Train 20 new agents from each district in filling out the SNIS tools in one 3-day session in 2017 and 2020	247,455,433	123,727,716	-	-	123,727,716	-
Objective 4: Strengthen the management of the supply	**1,992,480,980**	**645,491,838**	**447,283,751**	**141,302,210**	**262,249,091**	**496,154,091**

Objective / Activity	Total Cost CFA francs	2017	2018	2019	2020	2021
chain for vaccines, consumables and logistics at all levels.						
Activity 4.1: Procure 405 motorbikes for the Health and Social Promotion Centres in 2017	222,750,000	222,750,000				
Activity 4.2: Procure 13 motorbikes for civil society in 2017	7,150,000	7,150,000				
Activity 4.3: Procure 13 approved freezers for the Regional Health Directorates, 60 freezers, 70 approved VLS 400A refrigerators and 30 solar refrigerators for the Healthcare Districts and 177 approved solar/electric refrigerators, Model TCW 2043 SDD for the Health and Social Promotion Centres, in 2018, 2020 and 2021	779,879,660	-	350,629,660	-	54,750,000	374,500,000
Activity 4.4: Procure 2 electrical generators for the DPV and 13 solar power kits for DRS cold rooms in 2017	254,944,628	254,944,628				
Activity 4.5: Procure 2 trucks for the DPV in 2020	110,845,000		-		110,845,000	
Activity 4.6: Cover the training of 83 agents, including 13 EPI supervisors from regions and 70 EPI supervisors from districts regarding preventive cold chain maintenance in 2017 and 2019	89,941,238	45,293,119		44,648,119		
Activity 4.7: Cover repairs to 10 cold rooms of the DPV and 13 regional cold rooms from 2017 through 2021	439,500,000	102,900,000	77,900,000	77,900,000	77,900,000	102,900,000
Activity 4.8: Each year, cover the control/inspection of EPI warehouses (central and regional) regarding good vaccine and supply management practices for 2017 to 2021	30,770,454	6,154,091	6,154,091	6,154,091	6,154,091	6,154,091
Activity 4.9: Cover independent oversight of vaccine and supply availability at the healthcare facilities by civil society from 2017 to 2021	56,700,000	6,300,000	12,600,000	12,600,000	12,600,000	12,600,000
Total	**7,056,000,819**	**1,680,000,000**	**1,343,999,987**	**1,343,999,987**	**1,344,000,844**	**1,344,000,000**

List of Attachments

Mandatory Attachments	
No.	**Attachment**
Gavi-specific documents related to HSCC	
1	HSS grant application form
2	Approval of HSS proposal by the Minister of Health and the Minister of Finance
3	Official approval of subject-specific committees of the NHDP oversight for the application
4	Minutes of the meeting of the Subject-specific NHDP oversight committees approving the application for
5	**Minutes of the last three meetings of the subject-specific NHDP oversight committees**
6	**Extended work, budget and gap analysis plan**
7	**Two year extended procurement plan**
Documents related to the country's health sector	
8	2011-2020 National Health Development Plan (NHDP)
9	National M&E Plan (for the health sector/strategy)
10	Annual National Immunisation Plan (NIP)
11	Comprehensive Multi Year Plan – cMYP
12	Effective Vaccine Management (EVM) Assessment report (conducted within the preceding 5 years)
13	Most recent EVM Improvement Plan (or provide justification and identify a plan for developing an improvement plan)
14	Most recent Progress Report on the EVM Improvement Plan Implementation (should not be older than 6 months prior to application submission or provide justification as to why this is not available)
15	Terms of Reference (TOR) for the HSCC (TOR for the subject-specific committees of the NHDP National Oversight Committee)
Optional Attachments	
No.	**Attachment**
16	**Data quality assessment report(s)**
17	Data quality improvement plan
18	**Joint assessment of the national health strategy (ECSN)**
19	Detailed budget in Excel format
20	2015 MinHealth Yearbook
21	Performance Framework
22	Recommendations from Gavi-HSS 2 review
23	2014 SARA survey report
24	Criteria and statistical data for the 28 Healthcare Districts with low performance and 7 new Healthcare Districts

25	EMP-NHDP 2011-2020, Consolidated Report
26	Attendance list for the validation workshop on 30 August 2016
27	Attendance list for the adoption and approval workshop on 5 September 2016
28	Report on the Gavi3 application validation workshop on 30 August 2016
29	Gavi HSS2 final review report
30	JANS Report
31	Application examination meeting report
32	2014 RAR Report
33	Analysis of NHDP status according to pillars
34	CNS NHDP Inter-ministerial Decree
35	ICC Decree
36	Cold chain inventory final report
37	BFA Narrative Template HSS
38	Burkina Faso immunisation forecast
39	Burkina Faso Cold Chain inventory-National 2016
40	EMC 2014 poverty and inequality profile-2014
41	HDSP 2014-2018, final
42	2015-2017 three-year DSAP plan
43	Human resources workforce in health development plan
44	Pharmaceutical strategic plan
45	August 2016 PQS
46	EPI and AVC consideration workshop report
47	Feb. 2016 mid-point evaluation meeting report
48	Report on 1st ICC 2016
49	2016 2nd provisional ICC report
50	Final human resources in health motivation report
51	2016 RAR Report
52	2014 EPI in-depth review report
53	Terms of Reference (TOR) for the final BF HSS strategic plan
54	2016 DPV PA
55	Implementation status for the EVM improvement plan
56	Terms of Reference (TOR) workshop for GAVI HSS application approval

57	HDSP procedure manual