Cost of introducing and delivering malaria vaccine (RTS,S/AS01E) in areas of seasonal malaria transmission, Mali and Burkina Faso

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ABSTRACT

Background The WHO recommends use of the RTS,S/AS01, (RTS,S) malaria vaccine for young children living in areas of moderate to high Plasmodium falciparum malaria transmission and suggests countries consider seasonal vaccination in areas with highly seasonal malaria. Seasonal vaccination is uncommon and may require adaptations with potential cost consequences. This study prospectively estimates cost of seasonal malaria vaccine delivery in Mali and Burkina Faso.

Methods Three scenarios for seasonal vaccine delivery are costed (1) mass campaign only, (2) routine Expanded Programme on Immunisation (EPI) and (3) mixed delivery (mass campaign and routine EPI), from the government’s perspective. Resource use data are informed by previous new vaccine introductions, supplemented with primary data from a sample of health facilities and administrative units.

Findings At an assumed vaccine price of US $5 per dose, the economic cost per dose administered ranges between $7.73 and $8.68 (mass campaign), $7.04 and $7.38 (routine EPI) and $7.26 and $7.93 (mixed delivery). Excluding commodities, the cost ranges between $1.17 and $2.12 (mass campaign), $0.48 and $0.82 (routine EPI) and $0.70 and $1.37 (mixed delivery). The financial non-commodity cost per dose administered ranges between $0.99 and $1.99 (mass campaign), $0.39 and $0.76 (routine EPI) and $0.58 and $1.28 (mixed delivery). Excluding commodity costs, service delivery is the main cost driver under the mass campaign scenario, accounting for 36% to 55% of the financial cost. Service delivery accounts for 2%-8% and 12%-23% of the total financial cost under routine EPI and mixed delivery scenarios, respectively.

Conclusion Vaccine delivery using the mass campaign approach is most costly followed by mixed delivery and routine EPI delivery approaches, in both countries. Our cost estimates provide useful insights for decisions regarding delivery approaches, as countries plan the malaria vaccine rollout.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Malaria parasite transmission is highly seasonal across the African Sahel subregion. WHO recommends provision of the RTS,S/AS01 malaria vaccine in areas with highly seasonal malaria or areas with perennial malaria transmission with seasonal peaks.

⇒ Seasonal vaccine delivery may require new approaches and adaptations to existing routine childhood vaccination strategies, with potential cost consequences. No known evidence is available on the costs of seasonal delivery approaches for malaria vaccines.

WHAT THIS STUDY ADDS

⇒ This is one of the first studies to examine the costs of seasonal RTS,S vaccine delivery under alternative scenarios of vaccine delivery.

⇒ The non-vaccine economic cost of delivery per dose ranges between $0.48 and $2.12 across the three alternative scenarios considered. Vaccine delivery using a targeted mass campaign approach is most costly, followed by mixed delivery and routine EPI approaches requiring relatively fewer adaptations of existing routine immunisation programmes.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Countries planning to adopt and roll out the malaria vaccine in seasonal transmission settings should consider alternative vaccine delivery approaches, as guided by the local epidemiology, for achieving the desired impact. The options have varying cost implications to governments as evidenced by the findings in this study.

⇒ Final vaccine product price and the choice of delivery strategies will be important to assess the affordability and sustainability of delivery of the malaria vaccine.
INTRODUCTION
Malaria parasite transmission is highly seasonal across the African Sahel subregion with more than 60% of the burden occurring during the rainy season. Clinical trials in Burkina Faso and Mali evaluating RTS,S/AS01 (RTS,S) malaria vaccine use in areas with seasonal malaria transmission provided encouraging results suggesting substantial reductions in malaria disease burden by using the RTS,S vaccine alone or in combination with seasonal malaria chemoprevention (SMC). Drawing on this body of evidence, the WHO recommendation on widespread use of the RTS,S malaria vaccine invites countries to consider providing the vaccine seasonally, in areas with highly seasonal malaria or areas with perennial malaria transmission with seasonal peaks.

RTS,S use in the seasonal context may require new approaches to vaccine delivery. Feasible and sustainable modalities of seasonal vaccine delivery are yet to be determined and will likely be country specific, necessitating adaptations to routine childhood vaccination strategies with potential cost consequences. Country decisions around adopting new interventions are guided by feasibility of implementation as well as economic and other considerations, especially in resource-constrained settings. Understanding economic factors and cost of implementation is critical to inform the value of each delivery approach and assess the modalities to help inform decision-making and planning around further use of the vaccine. Some evidence of the economic feasibility of delivering a malaria vaccine is available. However, there is no known evidence on the costs of seasonal delivery approaches for malaria vaccines.

This study examines the cost of introducing and delivering the malaria vaccine in Mali and Burkina Faso, countries with seasonal malaria transmission. We evaluate the costs to the health systems in these countries, under alternative delivery approaches or scenarios within the context of seasonal transmission. Findings from this analysis will allow in-country and global policymakers to better understand the cost implications of implementing a new vaccine under alternative delivery scenarios and to assess the financial and economic feasibility of each option. Additionally, the cost estimates generated from the analysis could be used to inform cost-effectiveness and budget-impact analyses of the malaria vaccine to support country decision-making on the expanded use of the vaccine in seasonal settings.

METHODS
Study setting
Childhood vaccinations, in Burkina Faso and Mali, are managed by the respective National immunisation programmes and are delivered primarily as a routine service across all health facilities. Under routine immunisation, some outreach programmes are also regularly organised by health facilities to vaccinate eligible children closer to their communities. Additional ad hoc vaccination campaigns are organised on a need basis, for example, for polio, measles, COVID-19, and their delivery is often supported by partner agencies. Coverage of routine childhood immunisation is relatively high in both countries.

Scope and perspective
RTS,S is not currently used as a routine intervention in Mali or Burkina Faso. We, therefore, take a prospective (cost projection) approach to project costs of malaria vaccine introduction and delivery to the health system from the perspective of the two governments. The analysis considers costs incremental to the existing immunisation programme that may be incurred under an alternative implementation scenario. Cost estimates are generated for a period of 5 years starting in 2022 and assume national introduction in both countries. Any direct expenses identified as necessary for vaccine introduction and delivery are considered financial costs to the government. Such costs may be supported by external donor agencies or through new vaccine introduction grants from Gavi, the Vaccine Alliance (Gavi) in the future.

Target age group and schedule
The malaria vaccine is targeted for children between the ages 0–5 years. Children in their first year are considered eligible for the first dose, with the first three doses given to children at approximately monthly intervals. The current WHO recommendation is to provide up to five doses of the RTS,S vaccine to children approximately 12–18 months following the third dose, with an optional five-dose schedule for areas with highly seasonal malaria parasite transmission. This study followed the ongoing clinical trials in Burkina Faso and Mali looking at the benefits of the malaria vaccine given in conjunction with SMC, where over the course of 5 years, a child could receive a total of seven doses of the vaccine. While the current recommendation is to provide up to five doses of vaccine, evaluating costs of additional annual doses can provide insights into possible costs for the addition of annual doses through age 5.

Scenarios for costing
Routine childhood immunisation programmes primarily target children under 2 years of age and deliver vaccines on an age-based schedule. Using a seasonal approach to RTS,S vaccine delivery, children would likely receive a vaccination annually up to 5 years of age, well beyond the target age group of the Expanded Programme on Immunisation (EPI). Additionally, seasonally targeted delivery at the start of the disease transmission season is desired for the vaccine to be most impactful. These elements require adaptation of current routine immunisation programmes. Alternative vaccine delivery scenarios were generated with inputs from global experts as well as extensive consultations with in-country stakeholders, including decision-makers for new vaccine introduction and malaria programme managers. The discussions also...
built on and drew on insights from a qualitative study on feasibility and acceptability of the RTS,S vaccine and SMC delivery in country.\textsuperscript{5}

Scenario 1: Mass campaign
Under this scenario, three separate targeted campaigns, undertaken each year before the malaria parasite transmission season, are organised to vaccinate children with the first three doses of the vaccine. Children under 5 years of age, who complete the first 3 doses in year one, receive subsequent annual doses (doses 4–7) during the same mass campaign events.

Scenario 2: Routine EPI
Under this scenario, all doses are delivered through the existing routine immunisation delivery system. While children are encouraged to receive vaccination right before the transmission season, eligible children are given their vaccination any time throughout the year for the first three doses. Children completing first three doses are given subsequent annual doses also via the routine immunisation delivery system before the transmission season.

Scenario 3: Mixed delivery
Under this scenario, the vaccine is delivered using a combination of the mass campaign approach and the existing EPI delivery system. The first three doses are delivered to eligible children through the routine EPI schedule, as in scenario 2. Subsequent annual doses given to children who have completed first three doses are delivered via one targeted mass campaign each year before the transmission season.

Costing approach
We used an activity-based costing approach where specific activities under each scenario are identified and costed individually by mapping them with the potential resource requirements to generate cost estimates. The level of detail on the delivery strategies and activities, derived through stakeholder consultation, focused on the core components of costing. All activities are grouped into standard categories for the vaccination programme, such as procurement, planning, training, communication, sensitisation, social mobilisation and service delivery, that is, vaccine administration.\textsuperscript{9–11} Within each category, the levels and types of subactivities vary by implementation scenario and country, reflecting needs and current capacities as well as cost consequence. Detailed description of cost categories and subactivities by scenario are included in online supplemental appendix table 1.

We adapted the Malaria Vaccine Introduction Planning and Costing Tool (MVICT), developed and used previously to estimate the cost of malaria vaccine delivery,\textsuperscript{5} to account for the seasonal nature of the intervention in this analysis. The MVICT is a Microsoft Excel-based costing tool developed by PATH in collaboration with the WHO and Levin & Morgan LLC. The tool estimates the unit cost by activity and subactivities based on user assumptions for any given scenario. The tool can be made available to the readers on request.

Costs were further categorised as introduction (or initial set up) and recurrent costs as well as financial and economic costs.

Introduction costs consist of the value of resources that last longer than 1 year and include costs associated with purchasing capital resources (such as cold chain equipment) as well as non-recurring activities for introduction, such as initial training, social mobilisation and communication material development. Recurrent costs include operational costs of the programme such as the value of procuring vaccines, distribution, monitoring and supervision, personnel time as well as costs of short-term training activities that typically last less than a year.

Financial costs represent direct outlays of resources needed for vaccine delivery and include costs of resources purchased for programme implementation such as injection supplies, outreach allowances and per diem, resources used in training and new communication materials. Economic costs represent the opportunity costs of all resources and include all financial costs plus the value of existing resources within the existing immunisation programme that are used, specifically, salaries of current health personnel for their time used in malaria vaccine delivery as well as donated items. The cost of vaccine doses is excluded from the financial cost and included only in economic cost estimates under the assumption that the necessary vaccine doses would be donated to the government. Costs of other immunisation supplies, as well as vaccine procurement add-on costs (such as shipping and handling), are assumed to be financial costs to the government.

Costs of capital items were annualised over their respective estimated useful life years. Expenditures associated with initial setup were considered capital costs and were annualised and discounted at 3% over an assumed useful life of 5 years.

Data
Activity maps detailing specific subactivities required for vaccine implementation under each scenario were developed in discussions with the EPI programmes and were guided by recent new vaccine introduction experiences and programme expectations at the time of study conduct (April through December 2021). Key data inputs and assumptions regarding input resource requirements and unit costs (see online supplemental appendix table 2) were collected as part of the costing interviews with in-country stakeholders and administrative/financial record review. These data were informed by the recent new vaccine introduction in each study country.

To inform potential recurrent costs, we collected primary data from representative samples of health administrative units, vaccine stores and health facilities at regional, subregional/district and facility levels in two regions in each country. Districts and health facilities were selected by considering potential differences
Table 1  Key data input and assumptions used in the analysis

<table>
<thead>
<tr>
<th>Input</th>
<th>Burkina Faso</th>
<th>Mali</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccination schedule and target population</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target age group for vaccination</td>
<td>0–5 years</td>
<td></td>
<td>Assumption supported by clinical trial(^2)</td>
</tr>
<tr>
<td>Age and timing for first three doses</td>
<td>5–17 months at first vaccination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum number of doses per child</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of surviving infants in year 2018</td>
<td>805961</td>
<td>783972</td>
<td>Annual statistical yearbooks(^3)-(^5)</td>
</tr>
<tr>
<td>Population growth rate</td>
<td>3.00%</td>
<td>3.36%</td>
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</tr>
<tr>
<td><strong>Coverage and drop out</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage, dose 1</td>
<td>100%</td>
<td></td>
<td>Assumptions informed by EPI</td>
</tr>
<tr>
<td>Drop out, dose 1 to 2</td>
<td>4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop out, dose 2 to 3</td>
<td>8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage, dose 4–7</td>
<td>80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine product characteristics</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Vaccine presentation (dose per vial)</td>
<td>2</td>
<td></td>
<td>GSK(^6)</td>
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<tr>
<td>Vaccine packaged volume (cm(^3)/dose)</td>
<td>9.2</td>
<td></td>
<td></td>
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<tr>
<td>Vaccine wastage</td>
<td>10%</td>
<td></td>
<td>Assumed</td>
</tr>
<tr>
<td>Injection devices and safety boxes wastage</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine/injection device and safety boxes</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(buffer stock)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine price per dose</td>
<td>$5 ($2–$10)</td>
<td></td>
<td>Assumed(^6)</td>
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<tr>
<td>Cost per injection syringe</td>
<td>$0.20</td>
<td></td>
<td>Assumed, MVIP</td>
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<tr>
<td>Cost per reconstitution syringe</td>
<td>$0.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per safety box (100-syringe capacity)</td>
<td>$1.00</td>
<td></td>
<td></td>
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<tr>
<td><strong>Procurement add-on charges on as a % of product cost</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freight, insurance, inspection</td>
<td>7.60%</td>
<td></td>
<td>Assumed (observed during MVIP in Ghana)</td>
</tr>
<tr>
<td>Handling fee</td>
<td>3.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service delivery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of children vaccinated in routine outreach sessions</td>
<td>23%</td>
<td>40%</td>
<td>Primary data collected during health facilities survey</td>
</tr>
<tr>
<td>Average time spent per vaccination (routine fixed clinic)</td>
<td>10min</td>
<td>18min</td>
<td></td>
</tr>
<tr>
<td>Average children vaccinated per campaign site</td>
<td>200</td>
<td>500</td>
<td>Assumed</td>
</tr>
<tr>
<td>Average children vaccinated per routine outreach session</td>
<td>50</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td><strong>Salaries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff salary per month; range by staff cadre</td>
<td>64 000–525 487 CFA</td>
<td>16 377–40 155 CFA</td>
<td>17</td>
</tr>
<tr>
<td>Average vaccinators’ salary per month</td>
<td>53 333 CFA</td>
<td>22 778 CFA</td>
<td></td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exchange rate (1USD=)</td>
<td>575.6</td>
<td>575.6</td>
<td>18</td>
</tr>
<tr>
<td>Useful life years for introduction activities*</td>
<td>5 years</td>
<td></td>
<td>Assumed</td>
</tr>
<tr>
<td>Discount rate</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^*\)Not applicable for recurring activities.
CFA, West African Franc; GSK, GlaxoSmithKline; MOH, Ministry of Health; USD, US dollar.
that are anticipated to drive variation in cost of delivery. See list of districts and health facilities selected for data collection in online supplemental appendix table 3.

Quantities of vaccine and supplies are derived based on the projected birth cohorts/target population adjusted for the anticipated coverage provided by the national immunisation programmes. Any data gaps were supplemented by assumptions guided by country experiences with previous vaccine introductions. The consolidated data on all subactivities and the assumptions on respective input resources and unit costs used to generate the final cost estimates were all validated with the EPI programme representatives in each country. All cost data were collected in the local currency in 2021 units. Cost estimates are reported in both local currency units and in 2021 USD units.

Capacity consideration and shared input
We estimated the cold chain capacity (volume) requirement based on quantity of RTS,S doses needed and projected the costs of additional cold chain expansion at all levels. In Mali, new capital investments, especially vehicles for the EPI programme, were identified as necessary to fill in health system capacity constraints and were included in the cost estimates. To account for the incremental resource requirements for distribution in a routine setting, inputs shared with the existing system are attributed to RTS,S based on direct allocation (10%). The contribution of vaccinators to the malaria vaccine implementation is estimated based on time required to administer the vaccine under the routine EPI scenario, as reported by health workers during facility surveys. While there is the possibility of coadministration, we do not make specific assumptions on codelivery of RTS,S vaccine with other existing childhood vaccines in EPI schedule as we focus on the costs incremental to the existing vaccines. For a mass campaign, service delivery costs are estimated by accounting for the total number of days for each mass campaign session and the associated resource need. For all other resources, we assume 100% existing spare capacity in the immunisation system to accommodate malaria vaccine introduction and delivery.

### Cost estimates
The key outputs of the analysis are reported as the incremental cost per dose administration, cost of delivery per dose, cost per first three dose completion and cost of delivery per first three dose completion. Annualised cost of the introduction/initial setup costs for the study duration were added to the recurrent costs across all activity categories during the same period to generate the total cost of the programme. The cost per dose administered is calculated by dividing the total cost of the programme by the total number of doses administered throughout the duration of the analysis under a given scenario. The cost of delivery per dose is calculated by subtracting the commodity cost (vaccine and immunisation supplies) and the procurement add-on costs from the total cost and dividing by the total number of doses delivered. Costs per first three dose completion is calculated by dividing the total cost of the programme by the total number of children who receive at least the first three doses of vaccine.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Burkina Faso</th>
<th>Mali</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target population for vaccination</td>
<td>4539545</td>
<td>4796000</td>
</tr>
<tr>
<td>Projected vaccinations</td>
<td>19132211</td>
<td>2018622</td>
</tr>
<tr>
<td>Projected number of children completing the first three doses</td>
<td>4009326</td>
<td>4235827</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>Metric</th>
<th>Financial</th>
<th>Economic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost, annualised</td>
<td>29563102</td>
<td>145247375</td>
</tr>
<tr>
<td>Total introduction cost, annualised</td>
<td>2731879</td>
<td>3376512</td>
</tr>
<tr>
<td>Total recurrent cost</td>
<td>26831223</td>
<td>141870863</td>
</tr>
<tr>
<td>Total introduction cost, annualised</td>
<td>18067278</td>
<td>131965973</td>
</tr>
<tr>
<td>Total recurrent cost</td>
<td>2840869</td>
<td>3586112</td>
</tr>
<tr>
<td>Total introduction cost, annualised</td>
<td>15226408</td>
<td>128379861</td>
</tr>
<tr>
<td>Total recurrent cost</td>
<td>21579227</td>
<td>136245677</td>
</tr>
<tr>
<td>Total introduction cost, annualised</td>
<td>2715720</td>
<td>3379695</td>
</tr>
<tr>
<td>Total recurrent cost</td>
<td>18863507</td>
<td>132865983</td>
</tr>
</tbody>
</table>

EPI, Expanded Programme on Immunisation.
Results

Target population, projected vaccinations and total costs

Table 2 shows the number of vaccinations throughout the analysis period, 2022–2026. At an assumed coverage level at baseline (same for all scenarios, table 1), about 4.79 million and 4.5 million surviving infants are targeted for vaccination in Mali and Burkina Faso, respectively (table 2).

Sensitivity analysis

Baseline cost estimates are generated using the input values and assumptions in table 1. To understand the implications of input value choices on cost estimates, one-way sensitivity tests are performed for a subset of critical input data, over a range of alternative values, including vaccine price and coverage. Cost estimates under alternative input assumptions are reported separately.

Cost of delivery per first three doses completion is calculated by dividing the total cost of the programme net of commodity costs, by the total number of children who receive at least the first three doses of vaccine (see online supplemental appendix table 4 for calculations).

Patient public involvement

No patients were involved in this study. We have included roles and relationships between different members of the research team in the reflexivity statement (see online supplemental file).

Unit cost estimates

Across the three delivery scenarios, the financial cost per dose of vaccine administration to the target population is estimated to range from $49.8 million (Mali) and $18.1 to $29.6 million (Burkina Faso) (table 2). The economic cost for the 5-year period ranges from $144.9 to $171.1 million (Mali) and $131.9 to $145.2 million (Burkina Faso). The total programme cost includes annualised introduction costs and annual recurrent costs for a seven-dose RTS,S vaccine schedule (four-dose primary schedule plus three annual doses) for the duration of the analysis.

Unless otherwise noted, all cost estimates are based on an assumed vaccine price of US$5.00 per dose. The total financial cost (excludes vaccine cost), for the duration of the analysis, is estimated to range from $24.6 to $49.8 million (Mali) and $18.1 to $29.6 million (Burkina Faso) (table 2). The economic cost for the 5-year period ranges from $144.9 to $171.1 million (Mali) and $131.9 to $145.2 million (Burkina Faso). The total programme cost includes annualised introduction costs and annual recurrent costs for a seven-dose RTS,S vaccine schedule (four-dose primary schedule plus three annual doses) for the duration of the analysis.

Table 3: Unit cost estimates of seasonal malaria vaccine delivery, by vaccination scenario (in USD)

<table>
<thead>
<tr>
<th></th>
<th>Burkina Faso</th>
<th>Mali</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost of delivery per dose*</td>
<td>Cost per dose administered†</td>
</tr>
<tr>
<td>Financial cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mass campaign</td>
<td>$0.99</td>
<td>$1.71</td>
</tr>
<tr>
<td>Routine EPI</td>
<td>$0.39</td>
<td>$1.11</td>
</tr>
<tr>
<td>Mixed delivery</td>
<td>$0.58</td>
<td>$1.29</td>
</tr>
<tr>
<td>Economic cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mass campaign</td>
<td>$1.17</td>
<td>$7.73</td>
</tr>
<tr>
<td>Routine EPI</td>
<td>$0.48</td>
<td>$7.04</td>
</tr>
<tr>
<td>Mixed delivery</td>
<td>$0.70</td>
<td>$7.26</td>
</tr>
</tbody>
</table>

*The cost of delivery per dose is calculated by subtracting the commodity cost (vaccine and immunisation supplies) and the procurement add-on costs from the total cost and dividing by the total number of doses delivered.
†Cost per dose administered is calculated by dividing the total cost of the programme by the total number of doses administered throughout the duration of the analysis under a given scenario.
‡Cost of delivery per first three doses completion is calculated by dividing the total cost of the programme net of commodity costs, by the total number of children who receive at least the first 3 doses of vaccine.
§Cost per first three dose completion is calculated by dividing the total cost of the programme by the total number of children who receive at least the first three doses of vaccine. See online supplemental appendix table 4 for calculations.
Cost drivers

Recurrent costs constitute the major share of the total costs across all scenarios (online supplemental appendix figure 2). Introduction/initial setup costs constitute between 9.2% and 12.8% of financial cost and 2.3% and 4.4% of economic cost, across the two countries. Introduction cost share is relatively higher for financial cost under the EPI approach (scenario 2), which ranges between 16% and 38% of the total cost across the two countries.

The cost of vaccine procurement add-on and immunisation commodities constitutes the largest driver of recurrent costs across all scenarios, with costs ranging between 40% and 50% of financial cost and 30% and 40% of economic cost across countries. The share of cost due to vaccine procurement add-on under EPI approach is higher, ranging between 40% and 50% of financial cost and 30% and 40% of economic cost in comparison to mass campaign scenario.

### Table 4

<table>
<thead>
<tr>
<th>Metric</th>
<th>Coverage</th>
<th>Sn1: Mass campaign</th>
<th></th>
<th>Sn2: Routine EPI</th>
<th></th>
<th>Sn3: Mixed delivery</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mali</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per dose administered</td>
<td>High</td>
<td>2.71</td>
<td>8.86</td>
<td>1.47</td>
<td>7.38</td>
<td>2.00</td>
<td>7.93</td>
</tr>
<tr>
<td>Cost per dose administered</td>
<td>Medium</td>
<td>3.26</td>
<td>9.26</td>
<td>1.79</td>
<td>7.71</td>
<td>2.48</td>
<td>8.44</td>
</tr>
<tr>
<td>Cost per dose administered</td>
<td>Low</td>
<td>3.99</td>
<td>10.04</td>
<td>2.22</td>
<td>8.15</td>
<td>3.12</td>
<td>9.11</td>
</tr>
<tr>
<td>Cost per dose administered</td>
<td>EPI anticipated*</td>
<td>3.29</td>
<td>9.27</td>
<td>2.89</td>
<td>8.92</td>
<td>3.02</td>
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<tr>
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<td>5.76</td>
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<tr>
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<td>5.97</td>
<td>7.18</td>
<td>9.27</td>
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*EPI anticipated coverage was very high for dose 1 (100% for all scenarios in Burkina Faso but lower for Mali (Mass campaign: 90%, Routine EPI: 50% Mixed delivery: 70%). Coverage values in column ‘coverage’ is for dose 1. For the other doses, dropout rates used in the primary analysis (given in table 1) are used.

EPI, Expanded Programme on Immunisation.
financial cost across all scenarios. Service delivery under mass campaign constitutes 27% and 32% of the total financial cost in Mali and Burkina Faso, respectively. Under the mixed delivery scenario, service delivery accounts for between 8% and 10% of total financial cost. Excluding commodity cost, service delivery is the main cost driver for mass campaign delivery accounting for 36% and 55% of financial cost in Mali and Burkina Faso, respectively. The financial cost share of service delivery ranges between 2% and 8% under routine EPI and between 12% and 25% for the mixed delivery scenario. For economic costs, service delivery is the main cost driver under mass campaign delivery, accounting for up to 57% of the cost, whereas the economic cost share for service delivery ranges between 6% and 16% under routine EPI and between 14% and 27% under mixed delivery. The distribution of resource requirements, as a proportion of total costs, for each scenario is provided in online supplemental appendix Tables 5A–C and 6A–C.

**Sensitivity analysis**

The analysis shows that the unit cost estimates are most sensitive to vaccine price, and its impact is most substantial on cost per first three dose completion and economic cost for all scenarios. Overall, across the two countries under different coverage and vaccine price assumptions, the financial cost per dose administered ranges between $1.33 and $3.99 (mass campaign), $0.73 and $2.89 (routine EPI) and $0.92 and $3.12 (mixed delivery). The economic cost per dose administered ranges between $3.85 and $15.14 (mass campaign), $3.16 and $13.84 (routine EPI) and $3.38 and $14.40 (mixed delivery). Across the two countries, under different coverage assumptions, the financial cost of delivery per dose ranges between $0.91 and $3.28 (mass campaign), $0.37 and $2.18 (routine EPI) and $0.54 and $2.41 (mixed delivery), and the economic cost of delivery per dose ranges between $1.08 and $3.84 (mass campaign), $0.45 and $2.30 (routine EPI) and $0.66 and $2.56 (mixed delivery). The range of cost estimates under alternative coverage and vaccine price assumptions is in table 4 and online supplemental appendix table 7.

**DISCUSSION**

Seasonal vaccine delivery is uncommon especially in low-and middle-income countries (LMICs). The routine immunisation programme needs several adaptations to be able to accommodate seasonal vaccine delivery and achieve health impact. Necessary adaptations may include additional training activities and guidance to staff, increased human resource mobilisation in season, community mobilisation and sensitisation activities to encourage seasonal utilisation using mass vaccination campaign methodologies. These adaptations have cost consequences to the respective programmes. Several studies assessing costs of malaria vaccine delivery are available,5–7 yet all of these evaluate costs in the context of routine immunisation. Seasonal vaccine delivery cost estimates are almost non-existent, especially in the LMICs. Our study fills a knowledge gap on the economic implications of seasonal vaccine planning and effective decision-making around delivery approaches and resource mobilisation.

Our findings suggest that vaccine delivery using a mass campaign approach is most costly compared with other delivery approaches. Across the two countries, the economic cost per dose administered ranges between $7.73 and $8.68 (mass campaign), $7.04 and $7.38 (routine EPI) and $7.26 and $7.95 (mixed delivery). The financial cost per dose administered ranges between $1.71 and $2.71 (mass campaign), $1.11 and $1.47 (routine EPI) and $1.29 and $2.00 (mixed delivery). Administering malaria vaccine under the routine EPI scenario is the least costly option as this approach requires the least amount of adaptation to existing immunisation programmes. Under a mass campaign approach, three targeted mass campaigns would occur each year before the transmission season, which would require significantly different levels of effort and types of activities to prepare for and complete compared with the routine EPI approach (see online supplemental appendix table 1 for detailed description of subactivities across scenarios). For example, under the mass campaign approach, service delivery, which requires human resource mobilisation necessitating direct allowances for both staff and volunteers, is one of the major cost drivers accounting for between 36% and 55% of total financial cost (excluding commodity cost). On the other hand, service delivery (excluding commodity cost) accounts for 2%–8% and 12%–23% of financial cost under the routine EPI and mixed delivery scenarios, respectively. This corroborates the finding that mass campaign delivery, in general, is more costly at a given coverage level as it requires mobilisation of a large group of human resources,12 often diverting them away from routine health service delivery along with other resources. Mass campaigns, nonetheless, have capacity to achieve higher coverage than the routine immunisation scenario, which is not directly differentiated in this analysis.

In Mali, for the mass campaign approach, stakeholders indicated that an initial training for health workers when the vaccine is introduced, as well as annual refresher trainings before each campaign season, would be necessary activities. As a result, the financial cost for training was about 2.5 times higher under the mass campaign approach compared with the routine EPI approach in that country. Also, vaccine distribution costs during repeated campaigns added substantially to the total financial cost for mass campaigns, which was not the case for the routine EPI approach, which leverages existing vaccine distribution channels. The financial cost of vaccine distribution was between 1.5 and 2 times higher for the mixed delivery approach and between 3 and 4 times higher in the mass campaign approach, compared with the routine EPI approach. Furthermore, under the mass campaign approach, community mobilisation and sensitisation activities to encourage seasonal utilisation using mass vaccination campaign methodologies are essential.
approach, most planning and coordination, and sensiti-
sation and social mobilisation subactivities, are identified
as necessary each year, rendering higher recurring costs
for these categories under the mass campaign approach.
On the other hand, most planning and social mobilisation
activities were concentrated in year 1 only under the
routine EPI approach, and in years 1 and 2 only in the
mixed delivery approach. As a result, the total cost for
planning and coordination is more than double for the
mass campaign approach compared with the routine EPI
approach and even higher as compared with the mixed
delivery approach, particularly in Burkina Faso. In Mali,
the differences in total cost were about five times higher
for both the mass campaign and mixed delivery approach
compared with the routine EPI scenario. The differences
in cost estimates between the two countries partly reflect
the differences in input prices, including staff salaries,
among others.

Cost estimates are sensitive to underlying assumptions,
most profoundly the vaccine price, as shown in other
similar studies. Given malaria vaccines were not yet
recommended for broader use at the time of analysis,
uncertainty around various parameters is evident. Amid
uncertainties in implementing modalities at the time
of study conduct, potential activities for programme
introduction and delivery for each alternative scenario
of programme delivery were extensively discussed and
identified together with in-country stakeholders to
ensure the robustness of the cost estimates. However, as
the malaria vaccine product was not yet recommended
for broader use, these discussions with in-country stake-
holders, particularly around scenarios synthesis and
prioritisation of feasible delivery scenarios, were chal-
lenging, as there were uncertainties with regards to
delivery approaches and difficulties in articulating activ-
tivities to fit in with possible future needs. Due to this, only
the core components of the strategies were discussed
and included in the study. The assumptions made on
delivery scenarios as well as input resources are reliant
on the understanding of the discussants. The assump-
tions were informed by significant deliberation and
discussion and draw on previous new vaccine introd-
uctions using different delivery approaches including mass
campaigns.

A few studies have estimated that the economic cost
of delivering RTS,S under routine EPI in Burkina Faso
along with a few other sub-Saharan Africa countries.
Galaktionova et al. reported the economic cost of delivery
per dose (net of commodities) in Burkina Faso at $0.72.
Sicuri et al. reported the cost per fully vaccinating a child
with four-dose schedule using existing EPI platform to
be $2.58. Our results suggest that under the routine
EPI delivery, the cost per first three dose completion in
Burkina Faso is $1.62. While the cost estimates are not
directly comparable across these studies due to differences
in underlying assumptions and cost calculations,
estimates in the current analysis for Burkina Faso are
broadly aligned with the reported range.

Cost estimates generated from this analysis provide
useful insights into the cost drivers of alternative delivery
approaches and can be applicable not just to RTS,S but
also to other vaccines being considered for seasonal
delivery. While the estimates are generated for two coun-
tries in the Africa Sahel region with largely similar socio-
economic profile, the cross-country cost estimates provide
a range that may be used by other countries, not included
in the study, to estimate costs. However, we caution
against making extensive comparisons cross-country, as
we used a country-specific activity-based costing approach
reflecting specific inputs and assumptions agreed on by
each country team at the time of analysis.

Our study has some limitations. Cost projections are
largely dependent on the most feasible strategy chosen
for costing by country and is likely to be context specific,
limiting the generalisability of the results outside of the
study countries. Another potential limitation is the base-
line assumption that the same level of vaccine coverage
will be achieved across all delivery scenarios. This may not
be true as mass campaigns, due to their targeted nature,
are likely to achieve higher coverage as they bring vaccine
delivery closer to the communities, provide targeted
mobilisation of human resources including volunteers
for vaccine administration and promote strong commu-

nity mobilisation, which may not be consistent with
routine EPI delivery approaches. In the mixed delivery
approach, the one targeted mass campaign could likely
lead to higher coverage for the subsequent annual
doses as well as catch up children who missed vaccina-
tions via routine EPI administration. Given the lack of
knowledge a priori around these parameters, we look at
the impact of different coverage levels on the unit cost
estimates, which provides useful lower and upper bound
estimates under possible coverage ranges. The analysis,
however, does not account for the extra effort to increase
coverage and only reflects a change in the denominator.
The analysis also does not differentiate vaccine wastage
rates across the scenarios, though one can expect to see
variation in vaccine wastage rate by delivery scenario.
Nonetheless, the non-commodity cost of vaccine delivery
generated in the analysis reflects the recurring cost to
the programme, unaffected by some of the key unknown
parameters. The prospective cost projections in this
study builds on many assumptions, while informed and
validated by the EPI programmes in respective counties
based on their previous new vaccine introduction experi-
ences, would need further validation with actual costs of
implementation when the RTS,S vaccine is deployed in
seasonal settings.

The WHO recommends that countries consider a five-
dose malaria vaccine strategy in settings of highly seasonal
malaria transmission. The seven-dose schedule consid-
ered in this study was guided by the ongoing clinical trial
in these countries, looking at RTS,S vaccination along-
side administration of SMC. While the timing of seasonal
delivery of these interventions (RTS,S vaccination at or
before the transmission season and SMC administration

during the transmission season) may preclude direct coadministration of these two interventions, there might be some room for efficiency in coplanning and delivery, which is not investigated in this study. The definition of a fully immunised child (FIC) in the current context is not clear, and, because of this, we did not estimate the cost per FIC, opting instead to estimate the cost per first three dose completion.

Implementation feasibility and affordability are critical input in making decisions about whether or not to adopt new vaccines and also around planning for sustainable vaccine delivery. While cost of implementation is one of the critical components to assess feasibility and affordability of any new vaccine, the effectiveness of the delivery approach in achieving the desired level of coverage is also critical. Health impact is achieved through coverage, and this study does not address potential differences in coverage by delivery strategy. Therefore, it cannot inform the relative value of competing delivery strategies based on cost alone. This remains an important area for future investigation. Despite some limitations, this study provides useful information for decision-makers on the potential cost differences associated with several seasonal malaria vaccine delivery strategies.

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