



Lessons Learned: HPV Vaccine Introduction in Niger

March 2016

Exhibit A-6

LESSONS LEARNED: INTRODUCTION OF THE HPV VACCINE IN NIGER

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JSI, Research & Training Institute, Inc.
Exhibit A-6

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ACRONYMS

AEFI	Adverse Events Following Immunization
BCH	Building Capacities for Better Health in Africa Cameroon
CCL	Cold Chain Logistics
cMYP	Comprehensive Multi-Year Plan
CSI	Integrated Health Center (Centre de Santé Intégré)
CSO	Civil Society Organization
DI	Immunization Directorate (Direction des Immunisations)
DS	Health District (District Sanitaire)
EVMA	Effective Vaccine Management Assessment
EPI	Expanded Program on Immunization
Gavi	Global Alliance for Vaccine and Immunization
HPV	Human Papilloma Virus
ICC	Interagency Coordinating Committee
IEC	Information, Education, and Communication
JSI	John Snow Inc.
MoAH	Ministry of Adolescent Health
MoE	Ministry of Education
MoH	Ministry of Health
NGO	Non-Governmental Organization
PCV13	Pneumococcal Conjugate Vaccine-valent 13
PIE	Post-Introduction Evaluation
SV	Service de Vaccination
TOT	Training of Trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

INTRODUCTION

With assistance from Gavi, the Vaccine Alliance (Gavi) the Government of Niger conducted a pilot introduction of the HPV vaccine, beginning in 2013. The objective of the was to demonstrate in at least two districts (one rural and one urban) the capacity to vaccinate at least 50% of young girls aged 9-13 with all three doses of the vaccine before continuing into phase II and considering implementing the vaccine at national scale. In December 2014, Niger completed phase I of this HPV vaccine pilot introduction in three districts - two urban (Niamey 3, Niamey 4), and one rural (Madarounfa). The post-introduction evaluations (PIE, coverage survey and finance and cost study) for this phase were delayed, with completion in September 2015.

Because the HPV vaccine has a different target population than the usual routine immunization (RI) schedule (i.e. HPV vaccine is targeted for girls aged 9-13 rather than children under 1 year), it was necessary to develop a strategy that ensures that key messages reach parents, girls and community leaders and that girls are effectively mobilized for vaccination. The original strategy employed in Niger was a combination of a school-based approach and community-based approach (outreach - for girls not in school). Due to these specificities, new partners were necessary to maximize the chance of reaching these girls, including the Ministry of Education (MoE), the Ministry of Adolescent Health (MoHA), and UNFPA, as well as NGOs/CSOs working in the areas of adolescent health, girls' empowerment, and other related areas.

After completing phase I of the introduction, it was found that the original school and community based strategy proved to be very resource intensive and unlikely to be sustainable for scale-up. This report provides a summary of lessons learned from phase I of the introduction as well as details on the planning for phase II and considerations for scale-up of HPV vaccination.

PLANNING AND PREPARATION – PHASE I

Niger planned to introduce the HPV vaccine in early 2013. Unfortunately, due to the lack of technical support available in-country, and delays in the availability of funding to support preparatory activities, the HPV demonstration planning was further delayed until late 2013. In addition, there were continued challenges with the release of funding from the Common Fund as well as competing priorities at the Ministry of Health given several end-of-year evaluations and already programmed activities.

Recognizing the need for improved communication between the MoH and the Common Fund to help expedite the release of funding for introduction activities, initial activities by JSI (which started its technical assistance in October 2013) included facilitating communications between all key actors in-country to advocate for the release of the funding. In late 2013, partners successfully negotiated with the Common Fund to release funding to support the preparation for the demonstrations, including trainings and the vaccine launch. The official launch of the HPV pilot took place in Madarounfa in April 2014, with high level involvement

of representatives from the MoH (including the Minister), WHO, UNICEF, and UNFPA, as well as the Governor of Maradi, the Mayor of Djarataoua and the Mayor and Prefect from Madarounfa.

Checklist and timeline development

JSI and the DI team collaborated on a working checklist that was used to help monitor the DI's level of preparation for the new vaccine introduction (see Annex I). The checklist was organized according to the following topics: technical needs, cold chain and logistics, and communication and social mobilization. This linked with the integrated timeline of HPV activities (see Annex II), to be reviewed and updated once a week by the EPI team and technical partners for implementation according to their defined responsibilities.

Unfortunately, the implementation of the planned activities in the timeline were often delayed due to competing priorities with other important EPI activities, such as the annual program evaluation, polio eradication activities, and vaccination campaigns to prevent measles and neonatal tetanus. Due to this as well as staffing constraints, availability of partners to participate in the introduction planning was often limited, thus frequently requiring extension and revision of the chronogram.

Cold Chain preparation and preparedness

In early 2014, JSI supported a rapid assessment of the cold chain capacity and preparedness for the new vaccines (HPV, rotavirus and PCV). They found that at the central level, the cold rooms had the capacity to store the HPV vaccines for the pilot districts; however, storage capacity (including dry storage for syringes and needles) would become a challenge with the addition of the rotavirus and PCV13 vaccines. To address this at central level, JSI and the WHO country team worked to develop a proposal for Gavi's supply chain fund. Thereafter, UNICEF assisted Niger with purchasing and installing a new cold room, and JSI and UNICEF worked with the DI and other partners to ensure construction of a new dry storage depot. For the HPV demonstration districts and health zones, cold chain materials were supplied and in place in time for the introduction, with follow-up monitoring conducted to ensure daily maintenance and stock management. JSI also provided in-country logistics technical assistance to the DI logistician to improve monitoring of the HPV vaccine stocks and emphasize prioritization of their distribution and use before their expiration dates.

A more detailed assessment by the JSI/HQ Immunization Logistics Advisor in April 2014 assisted with identifying the existing capacity at all levels, distribution planning, data needs, and human resource capacity for logistics management (which also linked with the anticipated arrival of rotavirus and PCV-13 vaccines). In addition, an Effective Vaccine Management Assessment (EVMA) was conducted in Niger in June-July 2014, coordinated by WHO and UNICEF. The recommendations from that EVMA will serve to guide future decisions to address systemic concerns that affect all vaccines offered within the routine immunization system in Niger, including HPV. These supply chain implications need to be taken into account in system-wide planning by the MoH, including for HPV introduction beyond the two demonstration districts.

IEC/communications and social mobilization

Addressing communication needs was recognized as a critical element for HPV vaccine introduction preparedness. A communications expert from BCH-Africa, a regional CSO enlisted by JSI, assisted the team in Niger with communication coordination and support to develop key messages for the HPV introduction. He worked with Mrs. Ibrahim, Head of the Unit for Social Mobilization and Advocacy at the DI to conduct a qualitative study in November 2013, including identifying knowledge and concerns of parents, teachers and adolescent girls related to HPV vaccine. Based on this, he worked with partners to draft generic messages that were then pre-tested and finalized prior to the introduction of the vaccine in the two demonstration districts. He also facilitated the organization of the Communication Sub-Committee (MoH, UNICEF and other partners) and conversations/inputs to draft the communication plan for HPV vaccine introduction.

As follow-up (and incorporating the information from the qualitative research), a seven-day workshop with 40 participants from the MoH and partners was held in February 2014 to further develop and finalize the HPV communications plan and educative messages for social mobilization. During the workshop, key communications materials were drafted and reviewed, including the communications plan, messages for radio and TV, posters, pamphlets and fliers.

Additional components of the strategy to promote the HPV vaccine and introduction activities included: meetings with community organizations to sensitize them on the vaccine, dissemination of key messages in the media, door to door visits by community health workers to initiate community dialogues, and involving leaders from the education sector and other opinion leaders to contribute to the mobilization and vaccination of the target population. These activities were notably more successful in the rural district of Madarounfa than in the two urban districts in Niamey, for two primary reasons observed by the HPV working group and noted in the coverage survey and PIE: First, traditional leaders in rural areas are thought by the communication experts in Niger to have more power and influence than in urban areas. Therefore, once these leaders were convinced of the importance of the HPV vaccine, there was strong support amongst the community to ensure a successful introduction. Secondly, having the official launching ceremony (with participation of the MoH and other high level officials) take place in Madarounfa increased awareness and support in that district. In comparison, it is possible that the more diffuse social relationships in the urban areas of Niamey, combined with less concerted attention to social mobilization and insufficient CSO or other stakeholder involvement to reach communities and the target population, contributed to HPV coverage gaps/drop-out and issues with refusal in these urban sites.

Development of training and supervision tools

In preparation for the February 2014 HPV training of trainers (TOT) and cascade district and health worker trainings, the Interagency Coordinating Committee (ICC) Technical Sub-Committee reviewed and developed various tools for monitoring the HPV vaccine administration and coverage (e.g. tally sheets, vaccine register, summary sheets, and a supervision checklist).

Key preparatory steps for the vaccine introduction included:

- Defining the vaccination catchment areas for health centers and schools;

- Identification and enumeration of target populations of adolescent girls at community and school levels in each focus district, utilizing school data for each grade of girls in the target age range enrolled in the schools;
- Conducting informational and planning visits in each pilot district to orient and share information on the vaccine benefits with school and health center staff;
- Sensitization visits with representatives from schools, the community, CSOs, central level executives and UN organizations;
- Organization of a qualitative study in the focus districts to assess knowledge and identify concerns of parents and community leaders regarding the vaccine; and use of this information to develop key messages and a communication plan that addressed these concerns;
- Adaptation and tailoring of generic new vaccine training modules for health professionals, teachers and community volunteers and organization of trainings to include the HPV vaccine, syringes and associated reporting tools;
- Development of HPV-specific management tools and their advanced distribution.

Identification of target population

As part of field visits conducted by a senior JSI Immunization Technical Advisor in late 2013, a rapid study was carried out to calculate the target population. As an initial step, the study team visited the Inspector of Education in each district to obtain authorization and garner support from them and the primary school teachers for the processes and activities for introducing the HPV vaccine. The team also visited the Regional Health Director of Maradi to present the mission's objectives. In each district, the micro-planning tools were presented and the DI, JSI Advisors, and partners worked with stakeholders in each district to expand upon and refine the workplan and activity calendar.

Identification and calculation of the exact target population proved to be a significant challenge throughout the preparation and implementation of phase I of the demonstration. The District Management Teams, with the support of community volunteers and teachers, carried out a rapid, local census of target groups in the community and in schools. The target population for HPV vaccination had been specified as adolescent girls aged 11 years old. For girls not in school, the instruction was to target just 11 year old girls. To simplify vaccine administration through the school-based strategy, all girls aged 9 to 13 were vaccinated in schools (with this to be conducted in the class with the largest number of 11 year old girls).

In the two urban districts in Niamey, school girls in grade CM1 were targeted as the grade with the highest number of 11 year old girls; whereas in Madarounfa, CM2 was the grade identified. At the time of the vaccine administration in Madarounfa, however, the vaccination teams found that the higher number of 11 year old girls was actually in grade CM1, not CM2, which had repercussions on the coverage of 11 year old girls that should have received the vaccine. In addition, the school level census had not extrapolated the number of 11 year old girls out of the total girls aged 9-13 and not all schools had been included in the census. This resulted in confusion in calculating the coverage rate by age, as the exact denominator and proportion of 11 year old school girls vaccinated was not known. Likewise, there were also challenges with reliability of the census for girls in the community not enrolled in school.

Lessons learned from planning and preparation:

1. An HPV technical planning committee, led by the MOH and the MOE, needs to be established and fully engaged as soon as the decision is made to introduce and roll out the vaccine, to ensure broad-based, timely, and consistent support to adhere to timelines and planning.
2. The quality of the preparation and monitoring of operational components of the demonstration (microplanning, identifying the target population, monitoring and communication) need to be assured by the MOH and HPV vaccine introduction technical working group, particularly at district level, for the success of the vaccination;
3. Clarity on roles, management, timelines, and coordination within the MOH and with the Common Fund system can be strengthened. This will help with procedures for requesting, accessing and dispensing funds with sufficient lead-time to support the program roll-out, thus contributing to better compliance and more timely execution of critical path activities;
4. The awareness and perception of the importance of the vaccine and prevention of cervical cancer by the population and the health system organization is key for success, and they should be engaged in the process early in the planning stages;
5. Coordination between the health sector and the education sector requires prioritization and early and consistent co-planning can further improve the success of the vaccination activities;
6. The involvement of community leaders early and throughout the demonstration is important, not only for non-school girls but also for assisting with community awareness and mobilization of target populations;
7. Integration of adolescent health focal points/programs in schools can assist in motivating and encouraging girls' acceptance to be vaccinated;
8. The official launching ceremony in Madarounfa, with the MoH and other senior officials, was perceived by implementers to have contributed to the relatively more successful roll out of the vaccine in Madarounfa (compared to the Niamey districts). Therefore, social mobilization and advocacy efforts involving national and local leaders and media in all focus districts should be emphasized before, during and subsequent to the launch.
9. Cold chain and vaccine management and monitoring systems for a new vaccine entering the system should be in place and verified by the DI, ICC, and Gavi prior to the shipment of these vaccines to the central store.

CAPACITY BUILDING

Health professionals, teachers, and volunteers were involved in the demonstration and required orientation and training according to their roles and responsibilities. For the trainings to be most effective, separate sessions should have been organized and designed to

cater to each of these separate groups. However, due to funding and implementation delays with the first phase of the demonstration, training for these key actors was integrated and therefore lacked targeting of information to each of these groups' specific roles.

In addition, it was observed that the time allocated for the trainings was not sufficient to convey all of the needed technical and operational information. Note: If the training content was revised and based on the required competencies for each of these key groups to successfully play their role in HPV vaccination - including a competency-based job aide for trainees to refer back to after the training – then the duration of training may not be an issue.

Lessons learned on capacity building:

1. Separate or targeted training for health workers, teachers and community volunteers, based on their respective roles and core competencies, is recommended;
2. Complementarity and collaboration between members of the health and education sectors, including during training and for monitoring throughout the demonstration, is important for success;
3. It is necessary for health workers and teachers to have a reference document for their training, such as a key messages and “frequently asked questions” job aides, to which they can refer after the training.

COVERAGE MONITORING

As noted previously, census data were used to estimate the denominator of girls to be vaccinated with the first dose of the vaccine. Girls vaccinated with the first dose were then used as the denominator for girls to be vaccinated with the second dose. The following table summarizes the preliminary estimated coverage results from the administrative data on all three doses of the vaccine during phase one of pilot introduction.

Table 1: Estimated results of coverage for HPV1-3 (administrative data from the districts):

	Total Target Population	HPV 1			HPV 2			HPV3		
		Girls vaccinated in school	Girls vaccinated in the community	Coverage	Girls vaccinated in school	Girls vaccinated in the community	Coverage	Girls vaccinated in school	Girls vaccinated in the community	Coverage
Madarounfa	11 798	4217	6477	91%	3918	6211	86%	3909	5930	83%
Niamey III	4 308	1917	810	63%	1669	581	52%	1436	511	45%
Niamey IV	6 529	4272	1851	94%	3492	1511	77%	2879	1064	60%
Total	22 635	10406	9138	86%	9079	8303	77%	8224	7505	69%

Overall, the two districts achieved the target of reaching over 50% of eligible girls with the first dose during the demonstration, with an average of 84% coverage for girls aged 9-13 [66%-96%]. However, a large number of girls who were vaccinated in round one did not receive their second dose -only an average of approximately 51% of the girls vaccinated in round one received their second dose, resulting in a dropout rate of about 49% between HPV1 and HPV2. Major reasons for this high dropout rate were related to vaccine refusers and inadequate follow-up with defaulters and mobilization between rounds. This was especially the case in religious schools, when certain religious leaders had not been sufficiently involved in the planning and roll-out. This issue was most prevalent in the urban districts of Niamey 3 and 4, where the dropout rates were 75% and 73%, respectively. In Niamey 3, for example, leaders of religious schools (Muslim and Christian) refused to allow the vaccine to be administered in their schools, particularly the second dose. The introduction team observed that these leaders should have been more involved at all stages of introduction planning and implementation so that they were clear on the purpose of the vaccination, the need for multiple doses, and convinced of its safety and importance. Therefore, following administration of the second dose, efforts are increasing to disseminate key messages and sensitize the population on the importance and safety of the HPV vaccine, especially in Niamey 3.

Lessons learned from coverage monitoring:

1. The approach to identifying the target population (including involvement of local influencers and leaders), as well as the vaccination strategy used, can positively or negatively affect vaccine coverage and the quality of the coverage data. Community perceptions need to be considered and various stakeholders continuously engaged for monitoring and follow-up;
2. Increased involvement of religious leaders and school directors in planning and roll-out can potentially reduce the risk of dropouts, notably in the Niamey districts;
3. Ensure that staff are well-trained on the reporting requirements and that information on vaccine coverage is stratified by age as part of the reporting process to have clear denominators for calculating coverage rates.

PHASE I EVALUATION

If the vaccine had been introduced as originally scheduled, it would have aligned with the beginning of the school year, as recommended per the introduction strategy. However, due to the challenges noted previously, the launch of the vaccine could not take place until April 2014. This delay necessitated that the three dose schedule be carried out over the course of two school years, with the third dose administered in December 2014. There were also delays in carrying out the post-introduction evaluation and coverage survey, which should have been completed no later than October 2014 (six months after the start of introduction), but they were not able to be completed until September 2015.

Several critical challenges (as noted above) affected the success of completing this first phase of the pilot introduction. There were delays in transmission of information down to staff at district level alerting them to the status of the introduction planning process, as well as delays in the release of introduction funding by the Common Fund to allow activities to

begin. In addition, there was weak coordination between the health facilities and schools, and poor results from censuses of the target population that led to very poor quality of coverage data in certain district due to an unrepresentative denominator. Weaknesses were also observed in the media sensitization of community leaders, which led certain schools to refuse to allow the vaccination to take place, particularly in private schools.

Per the Gavi HPV vaccination pilot introduction requirements, a cost analysis and coverage survey were carried out by PATH in collaboration with partners. A post-introduction evaluation (PIE) was also conducted. These evaluations documented the results of the introduction and lessons learned and are being used to inform the second phase of the introduction.

Vaccine Coverage Survey

Several challenges arose in the planning and implementation of the coverage survey. First, it was difficult to fix a date to convene all key stakeholders, especially to ensure sufficient time for the results to be available before planning for phase two of the introduction began in October 2015. In addition, the survey was carried out during the school break, with most of the vaccination cards for the girls in school in the possession of the teachers and therefore inaccessible, making it difficult to verify certain recall information provided by girls through interviews. The biggest challenge, however, was obtaining the necessary funding for the survey – the Common Fund approval for the release of the funds took a very long time, thus delaying the implementation of the study until the school vacation was underway. The survey was conducted in July 2015 and the full report is available from the DI and PATH.

The following table illustrates the administrative data quality, compared to preliminary data from the coverage survey (card and recall):

Table 2: Comparison of administrative data with coverage survey results, by district.

	HPV 1 administrative results	HPV 1 coverage survey results	HPV2 administrative results	HPV 2 coverage survey results	HPV 3 administrative results	HPV 3 coverage survey results
Niamey III	63%	66.7%	52%	53.6%	45%	42.9%
Niamey IV	94%	54.5%	77%	39.2%	60%	23.6%
Madarounfa	91%	91.3%	86%	88.2%	83%	80.4%
Total	86%	72.8%	77%	62.9%	69%	51.9%

Post Introduction Evaluation (PIE)

Despite the delay in release of funding for the post introduction evaluation, it was successfully carried out from November 19th to December 2nd 2014. Key findings from the PIE included:

- While microplans were done at national level, there was insufficient micro planning in the Niamey districts.
- There were various challenges with identifying the target population. While there was a clear formula for calculating vaccine coverage, identifying an accurate denominator was a weakness. The census of target girls in Madarounfa was done well but was weak in Niamey 3 and 4.
- Due to delayed dissemination of information to district level, there was very limited time for planning introduction activities in the districts.
- As noted previously, the first dose of the vaccine did not align with the beginning of the school calendar year, as had originally been planned; thus the third dose had to be administered in the subsequent school years, complicating the tracking for girls that have received the first two doses.
- Involvement by the Minister of Education and other partners in the planning process was good.
- Training for teachers was weak, with the training manual and some supporting documents not available at all levels, and insufficient time allotted to ensure that teachers were sufficiently equipped with the needed orientation and information.
- Roles and tasks were not clear for the different actors involved in the trainings (health workers, teachers, community health workers)

See Annex III for a complete list of strengths and weaknesses identified in the PIE.

Cost Analysis

The cost analysis was also delayed by the slow release of funding for the activity. This also affected the availability of the local consultant charged with leading the analysis, who had to take another contract while waiting for the funding issues for the study to be resolved. The cost analysis was eventually completed in August 2015. The report found that, despite insufficient communications and sensitization efforts for leadership, these particular activities spent a significant amount of the introduction budget (34% of the total budget). A main finding was the challenge with allocating funds to the different levels – central level alone used around 52% of the budget that was earmarked for communications and training, while at operational level (where the majority of the budget was needed), only 39% was used. The analysis also did not include the additional costs associated with technical assistance (e.g. provided by JSI through funding from Gavi separate from the HPV pilot funding as well as the contributions of other partners financed outside of the pilot funding.) In total, the cost analysis found that the first phase of the introduction used 118,818,525 FCFA in year one – about 57% of the total available introduction budget (207,852,694 CFA). In comparing the cost study with the PIE and other observations, it is unclear as to the funds that remained after the first two doses were administered and whether the initial HPV pilot fund estimates were adequately allocated to cover all three rounds as well as a second year of the demonstration. In planning for the subsequent HPV rounds, additional funds were needed to fully complete the first phase and the second year, resulting in unspent funds from other vaccine introductions (e.g. the PCV and rotavirus vaccine introductions) shifted to cover remaining operational costs for the HPV pilot.

INTRODUCTION PHASE II – PLANNING AND PREPARATION

The second year of the introduction was originally planned to begin in October 2015 and follow the same strategy as phase one – i.e. a campaign-like approach involving seven days of school- and community-based HPV vaccine administration throughout the school year using a three dose schedule. However, the issues of sustainability and funding for this approach were raised during discussions between the DI and Gavi, particularly the concern over the high cost of implementing the current introduction strategy. The cost of introduction in the original three districts for the first phase alone was over 120 million CFA; and it was estimated that it would require more than two billion CFA to bring the vaccine to scale in all 72 districts by 2017. In addition, given the revised WHO/SAGE guidelines that HPV vaccine could be administered in two doses six months apart (rather than the 1-2-4 dose schedule Niger used in phase one), the country decided to shift to the two-dose schedule.

In addition to changing from three doses to two, it was also decided that the vaccine would be administered through the routine EPI system (rather than in the schools), with phase two to document the introduction experience using this new strategy and apply these lessons for eventual national scale-up. The new approach was approved by Gavi and the revised strategy document shared with all EPI staff and partners involved in the introduction, as well as with the introduction teams at regional and district level.

Phase two was then scheduled to begin in November 2015. Unfortunately, due to competing priorities, including polio NIDs and a national measles campaign, the DI staff were not able to work with the regions and health districts sufficiently in advance to develop and submit the phase two introduction to the Common Fund to enable fund release before November 2015.

Subsequently, a technical committee for Communications and Advocacy was created, comprised of communications focal points from WHO, UNFPA, the DI and the DI's Vaccination Division Chief to develop a communications plan and an action plan with accompanying budget for implementing the HPV vaccine introduction phase two. A new launch date was scheduled for February 6, 2016 and the Minister of Health sent out an official announcement. Due to the imminent expiration of 14,522 doses of the HPV vaccine in Niger (remaining from the first phase), a mini vaccination campaign was organized and the vaccine was administered to school girls in Niamey³ and Niamey⁴ on February 8th and 9th in order to use the vaccines before their expiration date. As of the time of this report, the strategy for the next phase of introduction (introduction through the RI system) and reaching girls vaccinated during the February campaign was being refined and the budget and funding request has been submitted to the Common Fund, with release of funds pending.

The following tables summarize some general observations from phase I of the HPV pilot introduction, areas that were identified as in need of improvement, and new strategies developed based on the identified needs:

Table 3: Lessons learned from phase I and application to Phase II

Planning and Preparation Elements	Areas needing improvement	Approaches proposed to address challenges after completion of phase I	Current status / outcome of strategy revisions for phase II
Perception of the importance of the vaccine among the population	Weak in Niamey – dissemination and understanding of key messages was weak	Intensify messages and sensitization, using the local media, and engagement of community leaders and local CSOs	Messages and sensitizations have been revised and community leaders identified.
Level of health system organization for integrating this vaccine, given the different target population from the routine EPI	Not very evident. The HPV demonstration was conducted through a campaign-mode with adolescent girls and not linked with routine EPI	Emphasize the target ages and rationale for HPV vaccination (e.g. during training and communication activities, emphasize that cervical cancer can be prevented in girls through early vaccination when the majority of these girls can be accessed – e.g. at school age) and determine how/if roll-out beyond the demonstration will link with routine EPI	In phase two, the vaccine will be integrated into the routine EPI system in three pilot districts and the experience documented to determine future approaches and scale-up.
Education sector interest in being involved in administering the vaccine to students	No promotion of adolescent health currently practiced in schools	Strengthen health promotion for adolescents in school and increase involvement of partners (e.g. CSOs, schools, parent/teacher groups, etc.) to focus on what was outlined in the proposal. Strengthen the coordination of assistance and support with the education sector.	It is planned that school health services be integrated into HPV vaccination in phase two. Also, UNFPA and women's' associations will be targeted for partnership on adolescent health.
Choice to vaccinate girls and not boys	Misconception that vaccine sterilizes girls	Clarify that the illness being prevented (i.e. cervical cancer) exclusively affects women	Posters and fliers will be circulated that clearly explain why girls are the primary recipients of the vaccine to protect them from cervical cancer.
Coordination between the health sector and the education sector	Weak coordination	Promote coordination by organizing course/conference on health and hygiene at school	Collaborative activities between the health and education sectors are planned to be provided through school health focal points (e.g. joint

			training and supervision)
Interest by influential community leaders in the vaccine	Weak interest by influential community leaders	Provide targeted training/sensitization for community leaders	Influential community and religious leaders have been identified to carry out sensitizations
Following up with and ensuring vaccination of drop-outs	Lack of organization/ training/ motivation at community level for active drop-out tracking and subsequent vaccination	Conduct an inventory of existing community organizations, review their terms of reference and train and incentivize them to work with the health facilities to identify girls that have dropped out and ensure that they receive the additional dose	Health districts have conducted an inventory of CSOs operating in their areas in order to involve them in vaccinating the girls.

Table 4: Proposed Phase II Strategy Improvements – school vs. community level

Activity	School Level	Community Level
Activity Microplanning	<i>Problem Identified:</i> Microplanning not sufficiently detailed	<i>Problem Identified:</i> Microplanning conducted in Madarounfa but lacked some detail; lacking in Niamey
	<i>Phase II Strategy:</i> Detailed micro planning in each school within health catchment areas in collaboration with CSI	<i>Phase II Strategy:</i> Improve microplanning in Niamey with support from community volunteers.
Census of target population to vaccinate	<i>Problem Identified:</i> Some lack of stratification of target population (particularly to disaggregate 11 year old girls); some schools did not have enumeration of targets	<i>Problem Identified:</i> Enumeration of targets frequently insufficient
	<i>Phase II Strategy:</i> Use student register to identify targets (CMI) and stratify target population in each CMI grade: 11 year old girls and 9-13 year old girls	<i>Phase II Strategy:</i> Work with community volunteers and leaders to conduct a head count for all 11 year old girls (to identify the full target population of girls in and out of schools).
Identification of targets by area	<i>Problem Identified:</i> Confusion of most appropriate grade with highest number of target girls, particularly in Niamey 3 & 4	<i>Problem Identified:</i> Verification of age was sometimes difficult in the absence of an identity card

Activity	School Level	Community Level
	<p><i>Phase II Strategy:</i></p> <p>Based on phase one experience, it has been agreed that girls in grade CMI have the highest number of the target population</p>	<p><i>Phase II Strategy:</i></p> <p>Work with parents to document the age of girls not in school during the assessment.</p>
Official Launch	<p><i>Problem Identified:</i></p> <p>No problems with launch –well managed and had a positive impact on program awareness</p>	<p><i>Problem Identified:</i></p> <p>Communities engaged; although more involvement needed post-launch</p>
	<p><i>Phase II Strategy:</i></p> <p>Continue with launch ceremony and follow-up advocacy for roll out in each newly selected district</p>	<p><i>Phase II Strategy:</i></p> <p>Increase involvement of communities to support implementation after launching ceremony</p>
Follow-up of drop-outs	<p><i>Problem Identified:</i></p> <p>Weak in Niamey 3 & 4</p>	<p><i>Problem Identified:</i></p> <p>Lack of incentives and monitoring for volunteers</p>
	<p><i>Phase II Strategy:</i></p> <p>Strengthen RI system to improve the monitoring and reduce drop-out rates</p>	<p><i>Phase II Strategy:</i></p> <p>If possible, provide incentive to volunteers and monitor their involvement to garner their support in identifying drop-outs and ensuring that they receive their doses</p>
Acceptance of the vaccine	<p><i>Problem Identified:</i></p> <p>Some vaccine refusal in Niamey 3 by religious school leaders (Christian and Muslim) and religious leaders</p>	<p><i>Problem Identified:</i></p> <p>Insufficient community involvement in urban areas, resulting in lower coverage</p>
	<p><i>Phase II Strategy:</i></p> <p>Identify religious schools where vaccine refusal occurred and provide specific messages to leaders in advance of each round</p>	<p><i>Phase II Strategy:</i></p> <p>Involve media and continue to sensitize the community in order to increase the uptake of vaccine</p>
Proportion of girls vaccinated	<p><i>Problem Identified:</i></p> <p>Inconsistent denominators</p>	<p><i>Problem Identified:</i></p> <p>Inconsistent denominators</p>
	<p><i>Phase II Strategy:</i></p> <p>Harmonize target population data</p>	<p><i>Phase II Strategy:</i></p> <p>Harmonize micro census data with the</p>

Activity	School Level	Community Level
	between data received from regional education level and population data received from schools	data received from regional statistics data

Lessons learned – planning for phase II

1. Given that a large proportion of adolescent girls are located in urban settings (e.g. in Niamey's districts), meetings, sensitizations, coordination and follow-up between the schools and health centers should be planned in each health zone well in advance of the dates when the vaccine is to be provided to ensure acceptance and participation.
2. For a school-based strategy, all efforts should be made so that the first dose of the vaccine is administered to correspond with the beginning of the school year, in order to have minimal drop-out between doses. As Phase II is rolled out, communication with the schools needs to be emphasized and messaging on the strategy made clear to school administrators, parents and other influencers to ensure that the girls come for the doses at the scheduled dates and locations.
3. The roles and responsibilities for the different stakeholders (vaccinators, community health workers, teachers, community leaders, etc.) should be clearly defined and all actors oriented during training sessions in order to improve the introduction process and vaccine coverage. As many stakeholders (teachers, health workers, community leaders, etc.) as possible should be included in introduction training and orientation.
4. To best inform the microplanning process, identify the target population and estimate vaccine coverage, a systematic census of girls aged 9-13 (both in and out of school) should be conducted by teachers and CHWs in each health zone in advance.
5. Health districts should be supported in the microplanning process by technical teams from regional level.
6. Health districts should have flexibility to allocate their introduction budgets based on what they judge to be the priorities, to prevent gaps in funding (as was the experience during phase one due to fixed funding levels prescribed for them by category

RECOMMENDATIONS FOR FUTURE INTRODUCTIONS

After the completion of phase I, the following general recommendations were identified for the next phase of the HPV demonstration and additional roll-out in Niger:

1. An HPV technical working group, led by the MOH (and engaging with the MOE and ICC partners) needs to be formalized and to meet consistently on a set schedule to promote the HPV vaccine implementation to ensure that the remaining activities are conducted and strategize (including liaising with Gavi) on the way forward for further

HPV vaccination plans. This HPV TWG will then provide oversight for the following recommendations, based on the agreed upon plan for further HPV vaccine roll out;

2. Ensure that the timeline, financial needs, and roles and responsibilities of the MoH/DI and partners are discussed and outlined with the ICC and Immunization Technical Working Group as soon as the decision is made to move forward with a new vaccine introduction. The full complement of key partners also need to be engaged early in the planning process (including for budgeting and developing agreed upon activity plans and timelines) and throughout implementation; this will help in organizing calendars, prioritizing and scheduling activities, ensuring availability of key focal points, and clarifying what finances are needed by when;
3. Prepare and provide immunization/HPV-tailored technical support early in the planning process to help with initial startup of the new vaccine introduction process and to support the key preparatory activities which lay the groundwork for a successful introduction;
4. Communicate on the needs and secure release of funding from the Common Fund well in advance so that it is available with sufficient lead time for preparations and trainings to take place according to the timeline;
5. Develop and continuously monitor the checklist of preparatory activities (led by the MoH and actively involving partners) to reinforce commitments and oversee the timely implementation of the new vaccine introduction;
6. Develop and regularly update a unified calendar and timeline of activities – that outlines in detail the HPV demonstration activities and also includes other campaigns, new vaccine introduction, annual planning processes, etc. to assist with timing and availability of human and financial resources;
7. Share and coordinate roles and responsibilities among leaders of the key partners and programs in order to avoid conflicting priorities with other activities during the application and initial planning process;
8. Intensify social mobilization and communication efforts in the urban districts (including for planning and roll-out for the second phase of the demonstration) and target CSOs and community leaders with the most influence, especially religious leaders, so that they support and promote the HPV demonstration and prevention of cervical cancer;
9. DI and partners should accelerate the process and implementation timeline for the second phase of the demonstration, including securing the funding for the cost study and adolescent health linkages to begin as soon as possible in 2016;
10. Make training documents and information on cervical cancer prevention available to all actors involved in the mobilization and vaccination of the adolescent girls.
11. Ensure that a large media campaign is carried out promoting vaccination of the adolescent girls.
12. Organize post-introduction workshops or meetings/dialogues with key stakeholders to share their observations/feedback and reflect on the vaccine introduction

ANNEX I: EXAMPLE CHECKLIST FOR HPV PILOT INTRODUCTION, NIGER, AUGUST 2014

N°	Issue	Status	Action(s) to be taken	Lead Agency / Focal point
I	Need for cold chain equipment			
A	National needs assessment with the cold chain team	Complete and the report is available. The analysis of inventory data was completed and shared with GAVI and other partners	-	UNICEF, JSI/GAVI and WHO under the coordination of EPI / CCL
B	Effective Vaccine Management (EVM) Evaluation	Completed	We await the report.	WHO consultant with the logistics sub-committee
C	Advocacy with new partners targeted at obtaining additional cold chain equipment	Ongoing. The inventory report analyzed and created by JSI has been largely shared with GAVI partners. One special proposal has been submitted to GAVI for CC strengthening at the central level. We await their orders through the common fund/GAVI.	We await GAVI's decision	EPI / logistics sub-committee Communications sub-committee, under the coordination of the EPI manager.
D	Storage capacity insufficient at regional level	Five cold rooms have been installed before the introduction of PCV13 and rotavirus vaccines in all regions except for Niamey.	Install the new cold room in the Niamey region.	CCL & UNICEF
E	Distribution plan to districts for new equipment	Apart from the regional cold rooms, The new CC equipment has not yet been received	We await the arrival of new equipment to propose a plan for distribution of equipment in stock on the basis of	CCL Department / EPI coordinated by the CCL subcommittee

N°	Issue	Status	Action(s) to be taken	Lead Agency / Focal point
			inventories which have been completed	
F	Distribution and installation of new equipment at the neighborhood level and health centers in the three pilot districts	Completed	-	UNICEF/DI
2	Revision of recording, reporting and of the monitoring EPI tools			
A	Review of technical orientation and other strategic EPI documents	Completed	These new EPI policies should be simplified and disseminated throughout the country.	DI and partners
B	Revision of all EPI management tools (tally sheets, vaccination cards, health cards, reporting forms, etc.)	Done. Management tools have been revised, printed and distributed before the decision on the type of vaccine that the country will use. Some errors exist in the revised tools	Gradually correct these errors during supportive supervision visits.	Technical sub-committee under the coordination of DI
3	Training of health workers and logisticians			
A	Availability of adapted training materials (trainer's guide, training modules for health professionals at the peripheral level)	Training materials were adapted, translated into French. Copies have been printed and distributed to trainers, but not health staff.	Print training materials for operational-level health staff.	Technical sub-committee under coordination of the DI?
B	Training of Trainers	These trainings have been completed in HPV demonstration districts.	Follow up on training through supportive supervision visits to districts.	Technical sub-committee
C	Training of health professionals at the	Training for health professionals and community members	-	Technical sub-committee

N°	Issue	Status	Action(s) to be taken	Lead Agency / Focal point
	operational level	has been completed.		
D	Logistics training (installation and maintenance of cold chain equipment)	Not yet	Organize training, plan specific next steps	Technical/Communications/ CCL sub-committee
E	Training of community health educators and/or security officials	Not yet realized	Train educators and community security officials	Technical/Communications/ CCL sub-committee
4	Advocacy, Communication & Social Mobilization			
A	Train and promote partners, mobilize necessary resources to buy additional CC equipment.	Completed but need remains	Continue with trainings	Communications sub-committee
B	Develop key messages (to address concerns from the KAP and from parents regarding the vaccine)	Complete. Key messages have been developed and pretested for HPV. Messages were diffused before the launch of the vaccine.	Continue to diffuse messages in the context of routine immunization, especially in places where there is resistance against vaccination.	Communications sub-committee
C	Identify and train media	The media are identified	Debut the awareness programs before the vaccines' introduction.	Communications sub-committee
D	Communication in the community	Completed but ongoing work is necessary	Continue with awareness programs	Communications sub-committee with community volunteers
5	Vaccine and injection material supply			
A	Register the vaccines with the National Regulatory Authority (ANR)	Yes	-	MOH
B	<ul style="list-style-type: none"> - Prepare a distribution plan - Ensure the storage capacity at the 	Complete Complete	Regularly supply the districts with vaccines and injection materials, with special	Logistics sub-committee and vaccine managers at all levels.

N°	Issue	Status	Action(s) to be taken	Lead Agency / Focal point
	regional level - Distribute vaccines and commodities	Complete	attention to stock management.	
6	Injection safety, waste management and disposal			
A	Availability of vaccines and syringes, needles, safety boxes, etc. at national level	Vaccines and injection materials already in the country Distribution was done in the provinces and from provinces to districts.	Ensure that vaccines and injection materials are always distributed following the bundling strategy.	CCL/MOH
B	Availability of functional incinerators in the health facilities	Current inventory shows there are 5 large modern incinerators (Maradi, Zinder (2), Tillabéri, Niamey). Maradi, Zinder (2), Tillabéri, Niamey). But nearly all CSIs are equipped with burners.	Create a circuit for the collection and transport of waste to incinerators where necessary. Decide on what will be done in health centers without incinerators?	CCL/MOH
C	Training on correct usage of incinerators	Not yet	Planning and conducting training (propose a date)	CCL/MOH
D	Other tasks (to define)			
7	Surveillance system updated for VPDs and AEFIs related to new vaccines			
A	Monitoring for AEFI is not functional- what should be done?	Integrate AEFI into the system of routine monitoring	Propose specific actions	
B	Training of supervision personnel	Build in IDSR Specific surveillance after the introduction of HPV, were discussed during NVI personnel training.	?	MOH

N°	Issue	Status	Action(s) to be taken	Lead Agency / Focal point
C	Monitoring and reporting system up to date for the new vaccine	Complete. EPI disease reporting tools have been updated with pneumo- and rotavirus-specific information	Sensitize and train clinicians in the case definition and reporting system of the diseases	MOH
8	Launching ceremony preparation			
A	Select introduction date	Dates were set. The first and second doses of HPV were administered in April and June 2014, respectively.	Prepare for the administration of the 3 rd dose of HPV in the three pilot districts;	Technical sub-committee (JSI to also support)
B	Determine the site for the launching ceremony	Completed for all vaccines.		Technical sub-committee and partners
C	Prepare the site with IEC materials and media	Complete		Technical and social mobilization sub-committees
9	Documentation			
A	Evaluation meeting for the 2 doses of HPV to identify challenges and lessons learned.	Not yet	Hold the evaluation meeting, identify lessons learned during phase 1 of the HPV demonstration and improve the preparations for phase 2 of the project (at the national level).	All the ICC sub-committees and partners
B	Link between new vaccine introduction and strengthening routine immunization within the EPI.	Not yet	Improvement of implementation plan; Strengthening of staff competency; Improvement of community use of vaccination services; Role of advanced	All the ICC sub-committees and partners

N°	Issue	Status	Action(s) to be taken	Lead Agency / Focal point
			vaccination services to reduce the number of unvaccinated children	
C	Plans for PIE	6 to 12 months after introduction		

ANNEX II: HPV INTRODUCTION TIMELINE

[illegible]

[illegible]

[illegible]

ANNEX III: RECOMMENDATIONS FROM HPV PIEi

Planification préalable à la mise en œuvre et processus d'introduction du vaccin

Forces de la planification	Faiblesses de la planification
➤ Existence de micros plans au niveau national	• Insuffisance dans la micro planification des districts de Niamey
➤ Recensement des filles au niveau des écoles et au niveau des communautés (Madarounfa)	• Temps limite pour la planification des activités au niveau des districts (retard dans l'information)
➤ Implication du Ministère de l'éducation et des partenaires dans le processus de planification	• Le choix du début de la 1ere dose non adapte au calendrier scolaire
Recommandations pour la planification	
➤ Elaborer les micros plans pour chaque district	
➤ Informer au moins deux mois à l'avance les districts concernés pour leur permettre de réaliser une bonne planification	
➤ Reconsidérer le mois de la 1ere dose lors de la 2eme année du projet de démonstration (Octobre)	

Formation

Forces de la Formation	Faiblesses de la formation
➤ Existence d'un guide de formation	• Manuels de formation non disponible à tous les niveaux et durée de formation insuffisante pour les enseignants
➤ Formation effective à tous les niveaux (central ; régional et district ; CSI)	• Absence de documents de support pour la formation des enseignants (fiche technique, présentations...)
➤ Principaux thèmes sur le vaccin anti-HPV abordés	• Non implication de tous les enseignants des classes ciblées dans les sessions de formation (32%)

- Formation/information des enseignants et leaders effective

Recommandations pour la formation

- Impliquer tous les enseignants des classes ciblées lors de la formation
- Rendre disponible guide/manuel/support de formation a tous les niveaux

Couverture vaccinale

Forces de la couverture	Faiblesses de la couverture
➤ Disponibilité des données sur les cibles scolaires et non scolaire	<ul style="list-style-type: none"> • Exactitude de la cible des filles non scolarisées (11 ans) peu fiable
➤ Existence de support de collecte des données (fiche de pointage, registres, carte de vaccination générique, fiche de synthèse	<ul style="list-style-type: none"> • Non utilisation de tous les supports (exemple fiche de synthèse) Non inscription du vaccin HPV sur la carte générique
➤ L'Age des filles vaccinées est enregistré	<ul style="list-style-type: none"> • Calcul des taux de couverture vaccinale HPV non systématique au niveau CSI
➤ Formule utilisée pour le calcul de la couverture vaccinale anti-VPH correcte	

Recommandations pour la couverture

- Rendre disponible tous les supports de collectes au niveau opérationnel (CSI)
- Systématiser le calcul des taux de couverture par CSI pour apprécier la progression journalière
- Impliquer les leaders communautaires dans la détermination de la cible non scolarisée.
- Poursuivre le calcul des taux de couverture par tranche d'âge et par statut de scolarisation à chaque niveau (CSI, district,

Administration des vaccins

Forces de l'administration	Faiblesses de l'administration
➤ Obtention du consentement verbal des parents et jeunes filles à la vaccination anti-VPH	<ul style="list-style-type: none"> Faiblesse de la logistique pour faciliter la vaccination au niveau des écoles
➤ Organisation de la vaccination au niveau des écoles a été facile	<ul style="list-style-type: none"> Information tardivement données aux écoles pour leur permettre de mieux s'organiser à recevoir la vaccination
➤ Dispositions prises pour maintenir un bon taux de retour des filles (conservation des cartes au niveau des écoles, adresses téléphoniques...)	<ul style="list-style-type: none"> Application des critères d'éligibilité non homogène Cible choisi souvent plus âgé que 11 ans
➤ Mise en place de stratégie adaptée pour la vaccination des filles non scolarisées (Madarounfa)	<ul style="list-style-type: none"> Possibilité de rattrapage limitée pour les filles ayant raté la 1ère ou 2ème dose
Recommandations pour l'administration	
<ul style="list-style-type: none"> ➤ Identifier/Utiliser les opportunités d'intégration pour rattraper les filles ➤ Vaccination en stratégie avancées ➤ Distribution d'autres intrants (MILLDA, déparasitage....) 	
<ul style="list-style-type: none"> ➤ Revoir les critères d'éligibilité ou inclusion des filles ➤ Communication sur la cible à vacciner (date de naissance/âge révolu!!!) ➤ Choix de la classe 	
<ul style="list-style-type: none"> ➤ Prévenir à temps (1 semaine au moins) les écoles des dates de vaccinations pour dispositions appropriées 	

Gestion de la chaîne du froid

Forces de la gestion de la chaîne du froid	Faiblesses de la gestion de la chaîne du froid
➤ Existence d'une CDF fonctionnelle jusqu'au niveau des districts et des CSI	<ul style="list-style-type: none"> • Absence de groupe électrogène dans la plupart des CSI • Faible connaissance de l'utilisation du Bridge Tag dans la plupart sont en low batterie
✓ Capacité de stockage des vaccins et intrants suffisants	<ul style="list-style-type: none"> • Faiblesse dans le suivi des relevés de température de la CDF dans certains CSI • Absence chambre de Freeze tag (chambre froide) • Absence de fiche de température • Absence mise à jour des fiches de température
	<ul style="list-style-type: none"> • Capacité de stockage insuffisante au niveau district et central • Vétuste de certains frigo nécessitant d'être remplacés
Recommandations pour la gestion de la chaîne du froid	
	➤ Mettre en œuvre le plan d'amélioration de la CDF (EGEV 2014)
	✓ Insister sur la composante CDF dans toutes les formations et supervisions sur le PEV.

Gestion des vaccins, transport et logistique

Forces de la gestion des vaccins, transport et logistique	Faiblesses de la gestion des vaccins, transport et logistique
➤ Vaccins et matériels d'injection en quantité suffisante : pas de rupture vaccin HPV	<ul style="list-style-type: none"> • Lieu de stockage et logistique de transport des vaccins insuffisants au niveau central
➤ Acheminement à temps des vaccins et intrants	<ul style="list-style-type: none"> • Rupture de stock de vaccins au niveau de certains sites de vaccination (3/12) • BCG • Pneumo
➤ Aucun vaccin périmé trouvé dans la CdF	

- Pas de vaccin trouvé au stade 3 ou 4

Recommandations pour la gestion des vaccins, le transport et la logistique

- Assurer une meilleure conservation des autres intrants par la construction de magasins au niveau central
- Augmenter la capacité de la logistique de distribution des vaccins Camion frigorifique (EGEV 2014)
- Mieux planifier les approvisionnements et la distribution des vaccins pour éviter les ruptures

Gestion des déchets et sécurité des injections

Forces de la gestion des déchets et la sécurité des injections	Faiblesses de la gestion des déchets et sécurité des injections
<ul style="list-style-type: none"> ➤ Existence d'incinérateurs dans tous les CSI 	<ul style="list-style-type: none"> • Incinérateurs non fonctionnels et non sécurisés dans la plupart des CSI • 64% des incinérateurs des CSI visités non sécurisés
	<ul style="list-style-type: none"> • Absence de fosses pour l'enfouissement
	<ul style="list-style-type: none"> • Présence d'aiguilles et de déchets tranchants à même le sol (40% des CSI visités)
Recommandations pour la gestion des déchets et la sécurité des injections	
<ul style="list-style-type: none"> ➤ Mettre en œuvre les directives en rapport avec la gestion des déchets 	

Perte de vaccins

Forces de la perte de vaccins	Faiblesses de la perte de vaccins
<ul style="list-style-type: none"> ➤ Présentation du vaccin : 1 dose 	<ul style="list-style-type: none"> • Taux de pertes non calculé par les CSB ; Pas de suivi des taux de perte
<ul style="list-style-type: none"> ➤ Faible taux de perte <1% 	<ul style="list-style-type: none"> • Calcul de taux de perte de vaccin non maîtrisé par quelque

Recommandations pour la perte de vaccins

- Calculer systématiquement le taux de perte des vaccins pour chaque CSB

Suivi et supervision

Forces du suivi et de la supervision	Faiblesses du suivi et de la supervision
✓ Supervisions menées avant l'administration du vaccin anti-VPH	• Disponibilité des rapports de supervision
➤ Existence de supervision intégrée prenant en compte les activités du PEV	• Absence de retro information aux structures supervisées

Recommandations pour le suivi et supervision

- Documenter les supervisions effectuées et partager les rapports avec les niveaux concernés

Manifestations post-vaccinales indésirables (MAPI)

Force des MAPI	Faiblesses des MAPI
➤ Système de notification de cas de MAPI connu à tous les niveaux	• Procédures nationale de suivi et de notification des MAPI concernant tous les vaccins non disponible à tous les niveaux
➤ Fiche MAPI disponible à tous les niveaux	• Kits de prise en charge des MAPI non disponibles avec les équipes
➤ Aucun cas de MAPI pendant d'administration du vaccin anti-HPV	

Recommandations pour les MAPI

- Mettre à la disposition des équipes des Kits de PEC des MAPI

Sensibilisation, communication et acceptation

Forces de la sensibilisation, communication et acceptation	Faiblesses de la sensibilisation, communication et acceptation
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➤ Une cérémonie officielle de lancement national a été organisée au moment de l'introduction du vaccin anti-VPH	<ul style="list-style-type: none"> • SENSIBILISATION insuffisante • Communication avec les parents non maîtrisée
➤ Implication des leaders et des enseignants dans la sensibilisation des filles et parents	<ul style="list-style-type: none"> • Beaucoup de Rumeurs: projet de "démonstration" = interprété par la communauté comme "expérience" Vaccin anti-HPV= contraceptif • Refus observées dans des écoles à Niamey (8 écoles)
<ul style="list-style-type: none"> ➤ Matériel de sensibilisation disponible ➤ Prospectus ➤ Tee-shirt ➤ Affiche ➤ Casquette 	Matériel rendu disponible qu'au 1er passage

Recommandations pour la sensibilisation, communication et acceptation

➤ Organiser des séances de sensibilisation avec la communauté et toute les personnes/groupes influents sur le nouveau vaccin à temps ;
➤ Impliquer toutes les personnes influentes dans la sensibilisation (leaders, enseignants...)
➤ Renforcer la compétence des agents de santé sur les techniques de communication avec les parents;
➤ Saisir toutes les occasions afin de rassurer les populations sur les inquiétudes suscitées par le nouveau vaccin

Pérennité

Forces de la pérennité	Faiblesses de la pérennité
➤ Existence de ligne budgétaire pour les vaccins traditionnels et le cofinancement	<ul style="list-style-type: none"> • Procédures de décaissement encore peu flexibles
➤ PPAC disponible en cours d'évaluation	<ul style="list-style-type: none"> • Pas de fonds spécifiques pour les nouveaux vaccins
	<ul style="list-style-type: none"> • Absence de financement de coûts opérationnels pour la vaccination PVH en deuxième année

Recommandations pour la pérennité

- Mobiliser des fonds pour les coûts opérationnels de la 2ème année du projet de démonstration
- Prendre en compte les nouveaux vaccins dans la ligne budgétaire
- Débloquer à temps le cofinancement de l'Etat pour l'achat des nouveaux vaccins.
- Rendre flexible la procédure de décaissement des fonds
- Réfléchir sur d'autres stratégies de vaccination du HPV plus pérennes pour minimiser les coûts opérationnels de la vaccination

Surveillance

Forces de la surveillance	Faiblesses de la surveillance
➤ Existence d'un registre des cancers au laboratoire d'anatomo-pathologie	<ul style="list-style-type: none"> • Le fonctionnement du registre des cancers au niveau national n'est pas optimal
	<ul style="list-style-type: none"> • Dépistage du cancer du col non systématisé dans toutes les régions
Recommandations pour la surveillance	
➤ Rendre plus fonctionnel le registre des cancers dans le cadre du plan de lutte contre les cancers	
➤ Systématiser le dépistage du cancer du col au niveau de toutes les régions	

Impressions générales

Forces générales	Faiblesses générales
➤ Introduction du vaccin anti-HPV généralement facile	<ul style="list-style-type: none"> • Problème d'organisation : chevauchement des activités
➤ Pas d'incidence sur le PEV et le programme de santé scolaire:	<ul style="list-style-type: none"> • Insuffisance de temps, changement de stratégie en cours de mise en œuvre, micro planification non respectée
➤ Pas de répercussions financières avec l'introduction du nouveau vaccin	<ul style="list-style-type: none"> •

Recommandations générales

- Éviter les chevauchements des activités
- Organiser à l'avance les activités
- Respecter le chronogramme prévu

ⁱ Évaluation Post Introduction du vaccin anti-PVH au Niger - Projet d'introduction/démonstration en 2014. Du 19 Novembre au 02 Décembre 2014.