LESOTHO

GARDASIL Access Program Lessons Learned

Presented by Julia Makhabane
Ministry of Health and Social Welfare

1st Global Summit on Women Cancers in Africa
Addis Ababa, Ethiopia
September 1, 2011

About Lesotho

- Lesotho is surrounded by RSA and it has the population of 1.88 million & Total Fertility Rate of 3.3 (LDHS: 2009)
- Lesotho has terrain that is mostly highlands with plateaus, hills and mountains with more than 1,800m above sea level
- The country is divided into ten administrative districts which differ in terms of size, topography, climate and stage of development
- The Age Standardised Incident Rate is 66.7/100,000 women (2006: MOHSW)
- Climate: Hot summers with heavy rainfall, extremely cold winters with snow & temperatures below-15 degrees celsius in the mountain areas

Program Design

- **Target Population:**
  - In 2009, target population was females aged 9-18
  - In 2011, target became 9-13 yrs. based on WHO guidelines

- **Partners:**
  - Other partners were Lesotho Boston Health Alliance, UNFPA (*United Nations Population Fund* - transport & t-shirts), WHO (transport & leaflets) while UNICEF, EGPAF (*Elizabeth Glaser Pediatric AIDS Foundation)*, ICAP (*International Center for Aids Care and Treatment Programs*) & PIH (*Partners in Health*) provided transport

- **Donation:**
  - 126,400 doses of GARDASIL were approved in 2008 for Phase 1 and 120,000 additional doses were approved in 2010 for Phase 2 (thanks to a pledge from Merck - known as MSD outside Canada and the U.S.)
  - Total approved = 246,400 doses
  - Total shipped to date = 206,400 doses (remaining 40,000 to be shipped)
  - MOHSW worked with Axios to coordinate the vaccine donation and manage the program

Program Design Cont.

- **Recruitment of girls and vaccine administration done through schools**
  - Makes it easier to reach targeted children and ensure follow-ups
- **Government involvement**
  - Has increased budget for EPI Programme from $483,871 to $2,741,935 in 2011 & other funds were put aside for procurement of cold chain equipment etc.
- **Community involvement**:
  - Religious leaders, chiefs, CHWs and teachers were involved in informing targeted children about vaccination dates, while parents provided consent for their children to be vaccinated

Program Design Cont.

- **Communication Activities:**
  - **Posters: Distributed to health centers/hospitals and targeted to health workers**
    - 1st poster with indications, contraindication, dosage, storage, side effects / 2nd poster with immunization schedule with intervals
  - **T-shirts: Worn by vaccinators on vaccination day**
  - **Stickers: Distributed to medical facilities to be handed out to children during vaccination days**
    - Stickers were placed in medical booklets marking when the child was vaccinated
  - **Media: Local newspapers, television and local radio stations**
    - Statement made by the Honorable Minister in the parliament on the prevention of cervical cancer was captured by media
    - One-on-one interviews with government representatives and district public health nurses

Progress To Date

- **Lesotho introduced the vaccine in March 2009,** targeting 9-18 yrs. females in two pilot districts:
  - 1st Round Coverage: 90.5%
  - 2nd Round Coverage: 94.6%
  - 3rd Round Coverage: 93.5%
- At the end of 2010, Lesotho re-applied and got 120,000 doses of GARDASIL
- **Lesotho started implementation of the 2nd phase of the vaccination program in the same two pilot districts in Feb. 2011** targeting 9-13 yrs. females based on WHO guidelines
  - 1st dose given to 19,915 females
  - 2nd dose given to 19,800 females (115 children were missed due to heavy rainfall)

Progress To Date Cont.

- **Improvement on Cold-Chain Management:**
  - Government is fully supporting the program, budget increased from $483,871 to $2,741,935 in 2011
  - Cold room site has been identified for increasing capacity storage for 2012, additional 100 refrigerators will be procured this year to cater for the future

- **Community and parents are involved**

Addressing Key Challenges

- **Plan for Climate : Unfavourable climate conditions affected the 3rd round immunization** campaigns, and as a result, some children were missed
- **Plan for Timing: Examination time affected the 3rd round –** use school calendar for planning vaccination sessions
- **Pregnancy**: Some of the females became pregnant and did not get 2nd nor 3rd doses (e.g. 33 children in different schools became pregnant)
- **Addressing Misconceptions: Use influential people like the parliamentarians & continuous health education to address misinformation** found online or transmitted through some health professionals

Lessons Learned

- **Annual plan that includes social mobilization and supportive partners is required** for implementation
  - **Continuous social mobilization** prior to and during implementation using local radios, TV & print is required for informing parents on the need to provide continued consent for their children to be vaccinated
  - **Resource mobilization is required for sustaining the program**, hence why it is important to sensitize parliamentarians as a means of making it easier to get financial support
- **Involvement of all stakeholders & other influential communities** is required to inform the targeted children (e.g. health professionals, teachers, chiefs, CHWs, church leaders, parents & children)
- **Networking** with developmental partners is required for provision of continued support (e.g. transport)

Lessons Learned

- **Parents need to be informed ahead of time** to solicit their support and to obtain their consent for vaccinating their children
  - Teachers who chose not to enroll children in the vaccination program were encouraged by parents who had been educated
  - Parents became more cooperative and allowed their children to be vaccinated because of the knowledge they had acquired during community gatherings

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Lessons Learned Cont.

- **Community Involvement**
  - Churches are a strong way to reach many people in the community
  - Community involvement is of importance as health professionals alone cannot reach all influential people, parents and follow-up with children

- **Use of Media**
  - It is important to involve local media when there is a vaccination round because they will often call again to find the total number of children vaccinated so that they can continue sharing information with community members – this then becomes another education lesson to the community
  - Continuous health education using different types of media is required to dispel myths & misconceptions among health professionals and passed through the internet, leading to some parents refusing vaccinations of their children

Lessons Learned Cont.

- **We have observed that implementation may be expensive only for the first year,** as the cost of implementation decreases as the total no. of targeted children decreases (first year: 9-13 vaccinated, second year: 9-year-olds only)
- **Implementation is easier when it is integrated with the EPI,** as existing structures like cold room, refrigerators, cold boxes, vaccine monitors etc., can be used
- **Involvement of the hospital management team** is of importance because when there are challenges, they are solved at a district level as they own the program
- **Emergency drugs are required at all the times during vaccinations** to guard against children who may have reactions

Conclusions

- **The MOHSW alone cannot prevent cervical cancer,** and there is need for multi-sectoral collaboration. Political will is required for sustainability of the program
- **Awareness creation is of importance to dispel myths and misconceptions** among the communities and among the targeted children
- **Networking with donors is of importance, as well as informing them about new Ministry initiatives** for the purpose of soliciting their support in prevention of cervical cancer and other cancers that affect the reproductive organs

The Ministry acknowledges the support of Axios and Merck for their donation of GARDASIL. Unity is strength and we can all be achievers in prevention of cervical cancer.

CAMEROON
GARDASIL Access Program
Lessons Learned

Presented by Lily Haritu (BNSc.)
Cameroon Baptist Convention Health Board

1st Global Summit on Women Cancers in Africa
Addis Ababa, Ethiopia
September 1, 2011

Program Design

This project is divided into two phases: I & II

- **Target populations**
  - Phase I: 1,600 girls aged 9-13
  - Phase II: 4,800 girls aged 9-13
- **Partners involved**
  - **International Partners: Drs. Thomas and Edith Welty (Associate Directors of CBCHB-ACP)**
    - Wrote the initial application, designed the implementation plan and provided partial funding for administrative cost
  - **Elizabeth Glaser Pediatric AIDS Foundation**
    - Financial support
- **Donation and program management**
  - Donation made possible by a pledge from Merck (known as MSD outside Canada and the U.S.) and is managed by Axios

Local Partners

Minister of Health & Prof Doh vaccinating a girl as a symbol of their support & approval during the launch

- Government of Cameroon via the Ministry of Health and Finance
- National Committee for the Fight Against Cancer Cameroon (NACFAC)
- Prime Minister of Cameroon
- Cameroonian philanthropists and local councils

Program Design Cont.

- **Recruitment methods**
  - Sensitization in schools, churches, community groups, clinics, public and private media
  - Advocacy visits to local and municipal authorities
- **Administration sites**
  - Phase I (Clinics and schools)
  - Phase II (Clinics, schools and community mother-daughter approach)
- **Government involvement**
  - One large government hospital in Yaounde currently offering HPV vaccinations on our behalf
  - Minister of Health presided over the official launch ceremony
  - Gardasil licensed and approved for use in Cameroon
  - Minister of Finance provided custom exoneration

Community Involvement

- **Community involvement:** The community was involved at all levels: recruitment, administration and follow-up
  - Villages and “Njangi”(traditional meeting groups): Initial entrance
  - Churches-sensitization and announcements
  - Schools-approval and administration

The Fon’s Rep. holding a poster

Staff before a Fon during a contact visit

Communication Activities

- Health talks and announcements in schools, churches, private and public media, mobile clinics

GARDASIL Phase I Coverage Rate

All Doses are Ongoing

1800
1600
1400
1200
1000
800
600
400
200
0

FIRST DOSE	SECOND DOSE	THIRD DOSE
1622, 100%	1516, 93.5%	1351, 83.2%

NUMBER OF GIRLS

GARDASIL Phase II Coverage Rate

All Doses are Ongoing

Category	Number	Percentage
Targeted #	4800	100%
First dose	1969	41.0%
Second dose	1068	54.2%

Progress to Date

- **Key successes:**
  - We are close to hitting our target of immunizing 85% of girls (who received the first dose) with all three doses for the first phase
  - The mother daughter approach has produced the best results so far
  - The government has been fully involved

Women awaiting screening

Girls brought on-site by parents from schools

Addressing Key Challenges

- **Establishing government support**
  - High priority for other childhood vaccines such as pneumococcus and rotavirus means ongoing need for advocacy to encourage that HPV vaccine reaches the same level of priority

- **Follow-up for subsequent doses**
  - Shipping delays due to administrative bottle neck, incorrect phone numbers provided, change of home and church address greatly contributed to this
  - One facility lost a list for girls who received 2nd doses, so the comprehensive database was used to trace those girls to confirm that they received 2nd doses

Addressing Key Challenges

- **Cold chain management**
  - Documented damage of five doses; long distances travelled to maintain cold chain during outreach
  - Recommend checking temperature at arrival at vaccination site and at time vaccine is returned to refrigerator to ensure vaccine stability

- **Limited funds to cover the administrative costs of the project**
  - Fundraising program established in which support was requested from key individuals in the country

- **Changes from initial implementation plan**
  - Originally planned to do both clinic and school-based vaccination to compare both strategies
  - Due to slow uptake with the clinic and school model, mother-daughter strategy was implemented

Lessons Learned

1. Seek Government buy-in well ahead of time
2. Conduct widespread sensitization well ahead of time
3. Evaluate potential effectiveness of various venues for vaccination
4. Assure ability to import donated vaccine without excessive cost
5. Source funding for administrative cost at the onset

Lessons Learned Cont.

6. Just prior to 2nd and 3rd doses, ask about any adverse effects from prior doses
7. Educate recipients on the need to complete all three doses on schedule
8. Consider every girl who shows up for subsequent doses as a potential contact person for girls who are lost to follow-up

Peer Tracing Method: The first girl was traced via telephone, she helped us trace the two girls in the middle and the two girls assisted us in tracing the third girl

THANKS FOR YOUR KIND ATTENTION...

MAY GOD BLESS YOU!

UGANDA
GARDASIL Access Program
Overview and Preliminary Lessons Learned

Presented by Margaret Sekyondwa
Mildmay Uganda

1st Global Summit on Women Cancers in Africa
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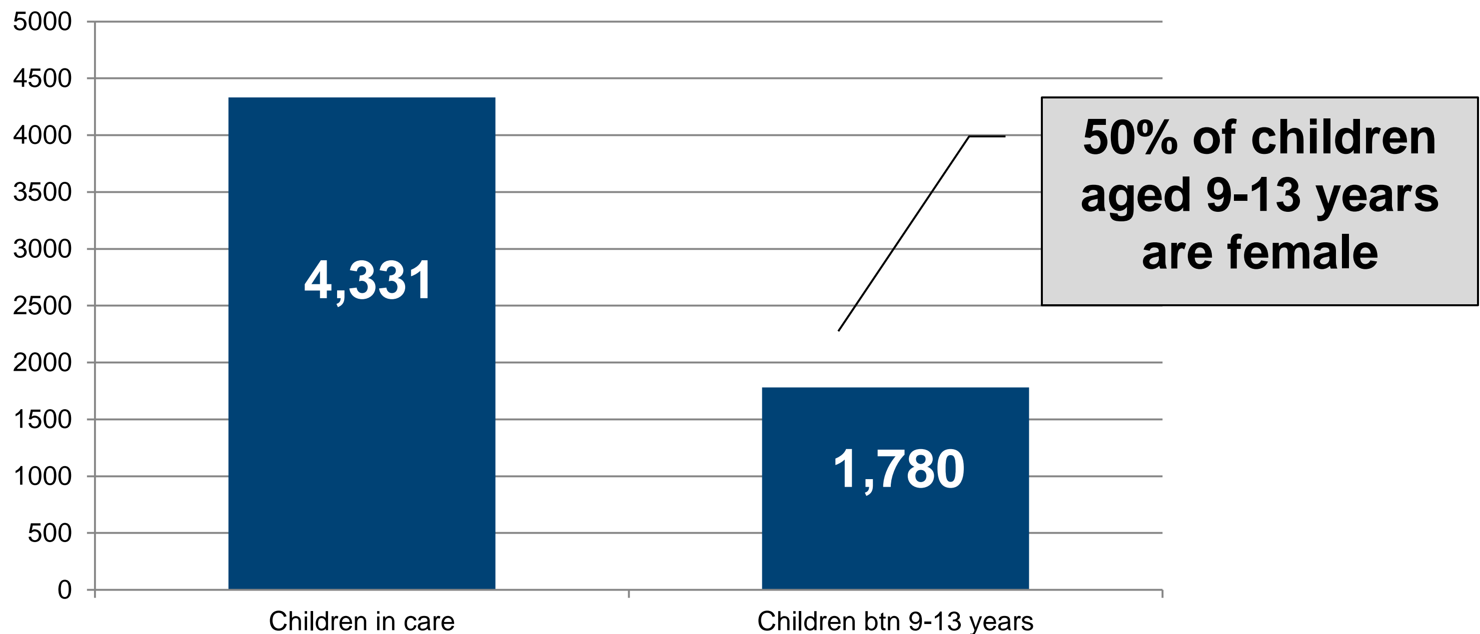
About Mildmay Uganda

- Mildmay Uganda (MUg) is a Christian NGO started in 1998 – a MoH facility run by Mildmay International
- Operates at the main site and community clinics
- MUg cares for a total number of 22,795 clients, among these 4,331 (19%) are children

MILDMAY UGANDA

MILDMAY
Transforming AIDS Care

Number of Children between 9 to 13 Years Receiving Care at Mildmay Uganda



Program Design

- **Mildmay received 1,600 doses of the HPV vaccine GARDASIL** to vaccinate up to 500 girls against cancer of the cervix
  - Donation made possible by a pledge from Merck (known as MSD outside Canada and the U.S.) and managed by Axios
- **Target population was girls aged 9 to13 years** accessing care at Mildmay Uganda main site, community clinics and satellite clinics
- **Delivery site choice:**
  - As Mildmay Uganda was already offering secondary cervical cancer prevention, we felt it was necessary to also offer primary prevention
- Mildmay Uganda **began HPV vaccination on January 19th, 2011**

MILDMAY
Transforming AIDS Care

Program Design Cont.

- **Training of doctors, nurses, counselors on HPV vaccine, benefits and risks, management of side effects and cold chain** was organized by Mildmay Uganda, in collaboration with PATH, Uganda Women Health Initiative (UWHI) and Uganda Expanded Programme on Immunization (UNEPI)
- **A lead nurse was identified** to ensure that the whole exercise and schedules for patients were well -managed
- **Seven nurses were trained in cold-chain management and one nurse took on the role of a cold-chain technician** to ensure proper running of the fridge
  - For close monitoring of cold chain, the fridge was put on children's ward, which works 24 hours

MILDMAY
Transforming AIDS Care

Recruitment Methods

- Girls 9-13 years receiving care at Mildmay Uganda and whose parents/carers had given consent were enrolled to receive three doses of the HPV vaccine
- Information was given on cervical cancer and the vaccine during morning education talks
- One week before the vaccination day, all carers with children on the list were contacted by phone to come and receive the vaccine from the clinic

Communications Activities

- **Tools Used:** Health education talks and posters of the female reproductive system
  - Sensitization of community health workers (CHW) and community-based volunteers(CBVs) was done by MUg staff
  - CBVs and CHW then helped in the sensitization and mobilization of the children for immunization
  - Local council meetings where held to sensitize members about HPV vaccination
- **Topics Covered:**
  - Cancer of the cervix and its causes, prevention of cancer of the cervix (primary and secondary), benefits and risks of vaccination and follow-up during and after vaccination
- **External Results:**
  - Program highlighted in *Nature*

MILDMAY
Transforming AIDS Care

Progress to Date

Number of girls vaccinated (January to August 2011)

Phase	I
1st dose	443
2nd dose	320
3rd dose	187

- CHW and CBVs followed up the vaccinated children for any adverse events; no adverse effects have so far been recorded
- **Reasons for lost to follow-up:**
  - Some children were in the middle of school exams
- **What we hope to do to improve the follow-up rate:**
  - Liaise with the CBVs to further contact the parents/carers
  - Call parents to remind them about the appointment dates
  - Get physical addresses of the children to follow-up

Addressing Key Challenges

- **Need for flexibility in the dates for vaccination and reminder to parents about the dates and time for vaccination**
  - Children delayed in arriving to satellite clinics; limited funds for the implementation program
- **Secure physical address of children for follow-up purposes**
  - Some children provided incorrect telephone contacts
  - School program (which coincided with the subsequent doses) made it tough to ensure follow-up as it was difficult to get the children out of school
  - Cost effectiveness becomes an issue when follow-up is required for only a few children
- **Consider using extra ice packs to ensure cold-chain management**
  - Forty one (41) doses were damaged as a result of failure to maintain the cold chain during transportation of the vaccines from the satellite clinics

Preliminary Observations/Lessons Learned

- **Acceptability is high**
- The **vaccine was readily accepted** by both the carers and the children
- **Sensitization talks** helped the carers and children to easily accept the vaccine
- **Use vaccination day to encourage cervical cancer screening for adults**: On the HPV vaccination days, female carers escorting the girls were also screened for cervical cancer using the VIA method and for breast cancer using the palpation method

Additional lessons learned to be included once project is completed.