Overview of Gavi's support for HPV vaccination programs in low- and middle-income countries (LMICs)

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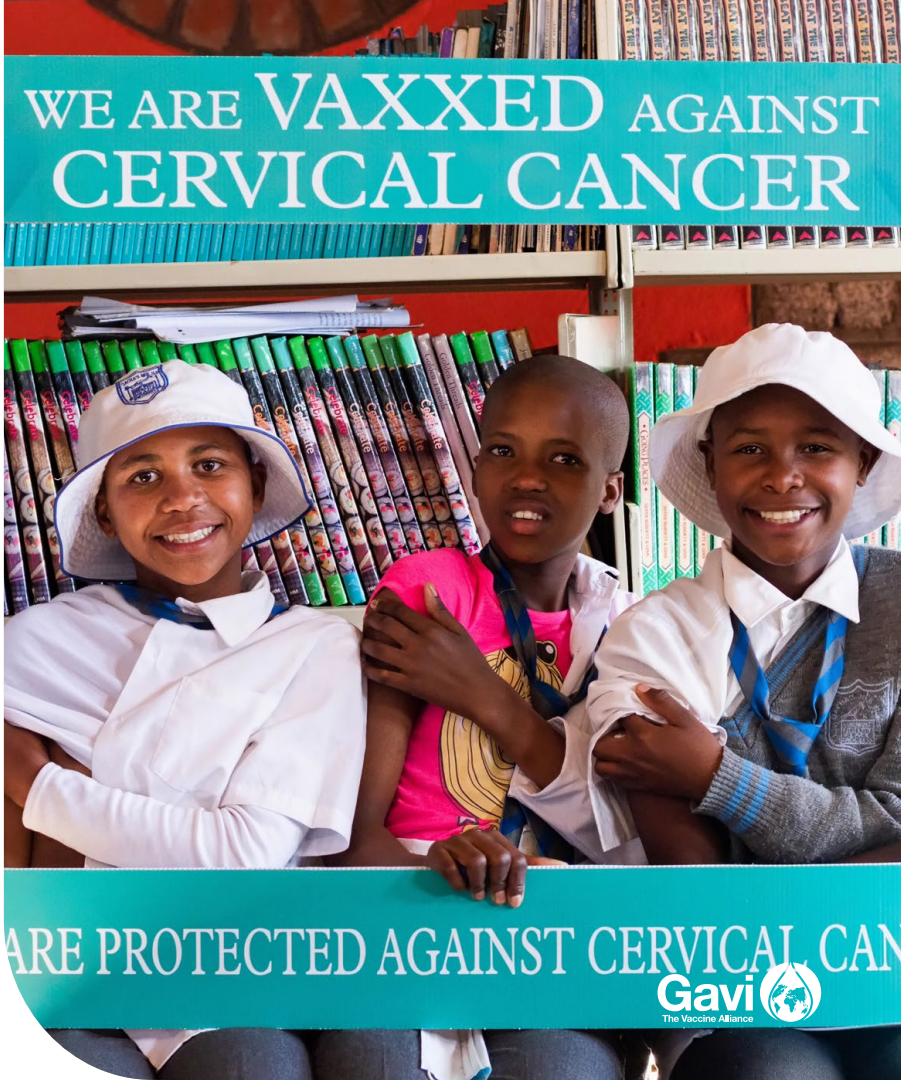
South Asia Regional Meeting

HPV Prevention and Control Landscape and the way forward.

13th , 14th and 15th - Dec 2022– New Delhi, India.

Gavi's HPV programme

1. Background
2. Gavi's support for HPV
    1. Low and lower middle-income countries (LMICs)
    2. Middle Income Countries (MICs)
3. Lessons learned

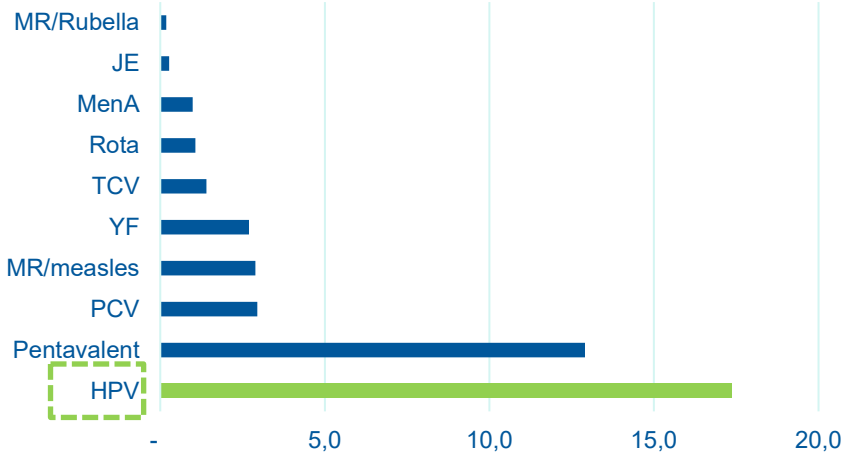


HPV vaccination is critical to reach Gavi's 5.1 goals

HPV is critical to Gavi's strategy and IA 2030

- Reducing cervical cancer death, HPV is amongst the **highest impact of Gavi's current vaccine portfolio**
- Contributes to **gender equity**
- Can strengthen adolescent immunisation platforms for **life-course vaccination**
- HPV programme can contribute to **learnings on integration of immunisation into Primary Health Care*** *(notably adolescent health)*

Impact rates (deaths averted per 1,000 vaccinated) for Gavi-supported vaccinations

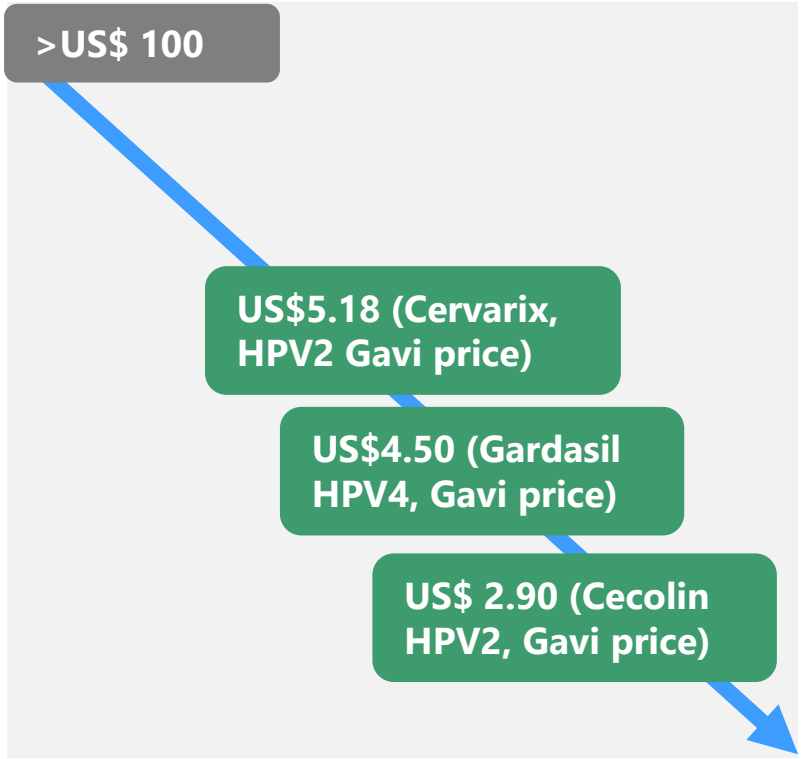


Source: Gavi portfolio data representative of Gavi funded impact from operational forecast version 19

Note: Many of Gavi's current portfolio vaccines have been widely introduced and scaled in Gavi-supported countries

*Note: important learnings in view of Gavi 6.0

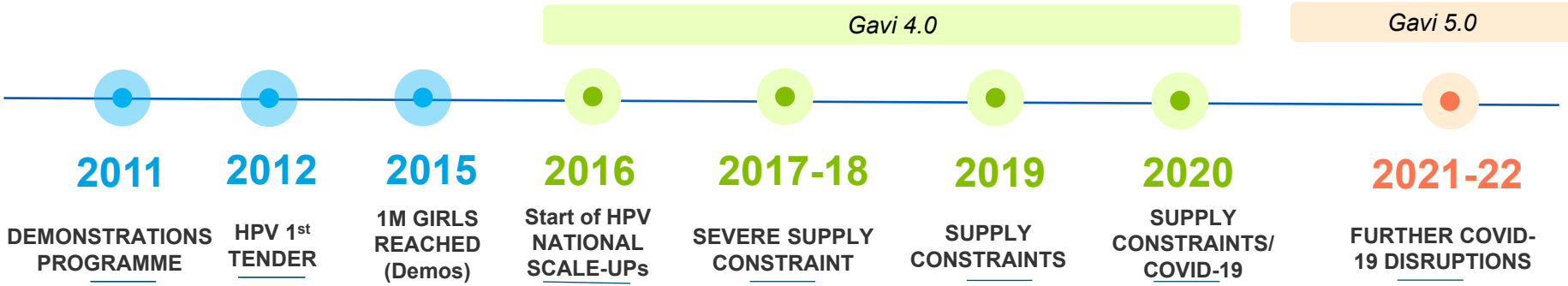
Affordable HPV Vaccine Price for Gavi countries and eligibility



Routine	A single cohort of girls to be immunised on a routine basis. (e.g., 9 years)
Multi-Age Cohort (MAC)	Countries have the option to immunise additional girls within the recommended age-group, who are older than the routine cohort. (e.g., 10-14 years)

Gavi's HPV programme to date has experienced some setbacks

Historical background



Reach to date

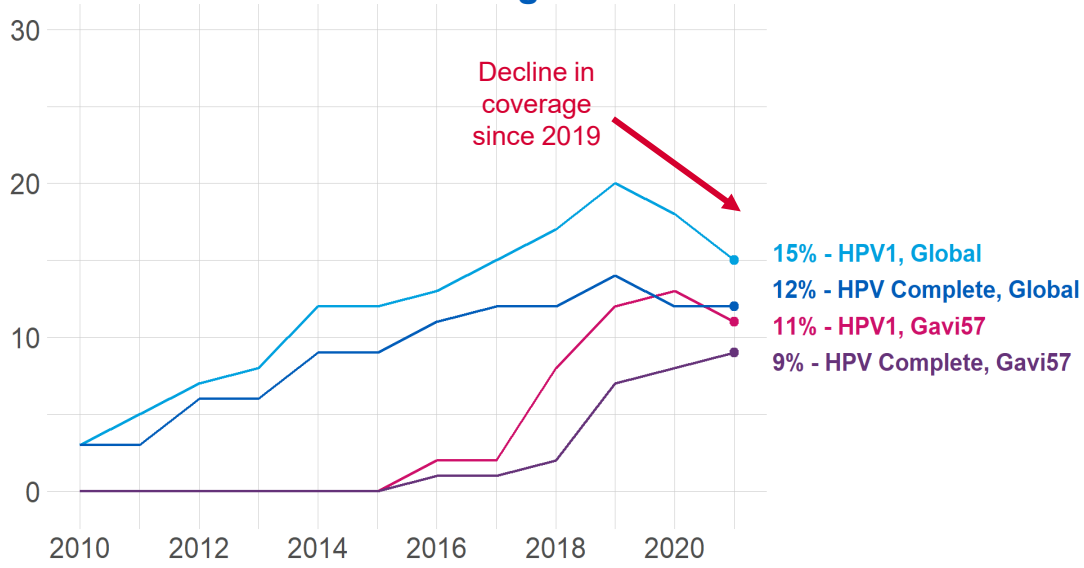
✓ Girls reached: **9.8M**

✓ Introductions: **29 Routine & 11 Multi-Age Cohort (MAC) catch-ups**

✓ Gavi 73 coverage: **11% HPV1, 9% HPV2**
- Large countries yet to introduce
- Mixed country-level performance

With improved supply and 1-dose permissive recommendation, now is the time to inject momentum into HPV vaccination

Global vs. Gavi57 HPV coverage trends: countries need support to introduce and recover coverage



Positive enablers for rebuilding momentum

- SAGE 1-dose schedule permissive recommendation
- Increased supply (expected to triple 2022-2025)
- Acute phase of pandemic slowed

With the recent Gavi board approved HPV relaunch, ≈86 million girls could be reached by 2025

Ambition

Fully immunise ≈86M girls with HPV vaccine by 2025

Goals

- Accelerate **cervical cancer reduction** in Gavi eligible countries
- Further contribute to **gender equity**
- Build and strengthen **adolescent immunisation platforms for life-course vaccination** and **learnings** in view of Gavi 6.0
- Start building **stronger Primary Health Care (PHC) for adolescents** through integration

Objectives

Accelerate quality introductions

Rapid coverage recovery

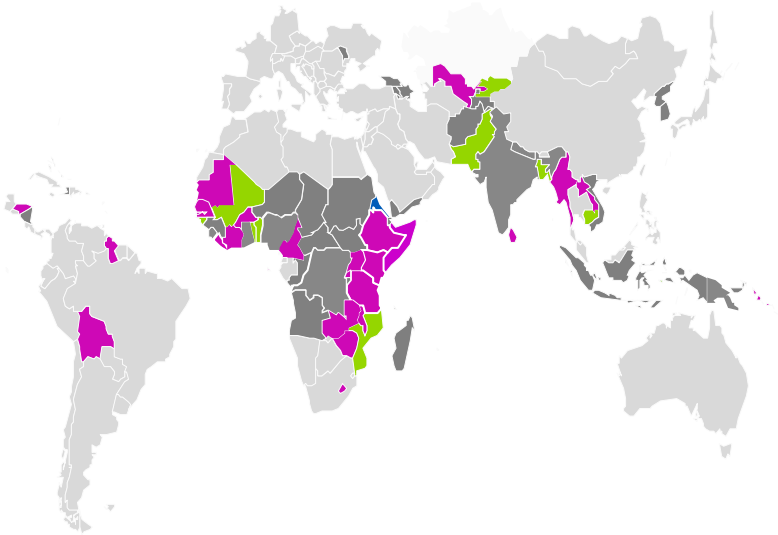
Sustainability through **integration (EPI-PHC)**

LMICs eligible for Gavi support

List available here

Initial self-financing	Preparatory transition phase	Accelerated transition phase
Afghanistan	Benin	Bangladesh
Burkina Faso	Cambodia	Côte d'Ivoire
Burundi	Cameroon	Djibouti
Central African Republic	Comoros	Ghana
Chad	Republic of Congo	Kenya
Democratic Republic of the Congo	Haiti	Lao People's Democratic Republic
Democratic Republic of Korea	Kyrgyzstan	Nigeria
Eritrea	Lesotho	Papua New Guinea
Ethiopia	Mauritania	São Tomé
Gambia	Myanmar	Solomon Islands
Guinea	Nepal	
Guinea Bissau	Pakistan	
Liberia	Senegal	
Madagascar	Tajikistan	
Malawi	Tanzania	
Mali	Zambia	
Mozambique	Zimbabwe	
Niger		
Republic of Sudan		
Rwanda		
Sierra Leone		
Somalia		
Sudan South		
Syria		
Togo		
Uganda		
Yemen		

Eligible countries who have introduced HPV



29 National introductions

5 Approved National Programmes

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We will accelerate adoption of one dose schedule in Gavi eligible countries (incl. India & MICs) per country decision

	Programme design updates	Funding approach
Routine Cohort (i.e., 9 years)	• Countries will be **encouraged to implement same schedule for routine/MAC**, for a given product, to ensure programmatic ease	• **Switch grants provided ($0.80 per targeted girl in the routine cohort)** • **Vaccine introduction grant (VIG) $2.40/target** - *Optimizes VIG funds to achieve coverage*
Multi-Age Cohort (MAC) (i.e., 10-14 years)	• **Primary target remains 10-14yrs girls** • **Countries with delayed MACs** and entire cohorts of girls have aged out of the primary target (>14 years of age), **allow catch up of missed cohorts up to 18yrs, if they opt for 1-dose**	• **Ops $0.45/55/65/target per country transition** • *Rationale:* − *Optimizes current ops funds to achieve coverage* − *Maximizes impact of available supply*

We will also support countries through HSS, TCA and operational learning

HSS investments: US$ 40m

- Cost-effective, pro-equity service delivery models
- Demand generation
- Strengthen data systems

Enhanced technical assistance: US$ 30

- Decision-making & introductions; reinforced planning & implementation
- Multi-sectoral programming; advocacy & financing
- CSOs (women and youth led organisations)

Learning agenda: US$ 15m

- Integration of HPV vaccine in routine delivery mechanisms & PHC
- Integration with other adolescent health services & cost-effective packages
- Impact & feasibility evaluations

India specific support for HPV

- Sikkim state introduced HPV vaccination in 2018 & Punjab state conducted an HPV pilot in 2017
- In June 2022, the NTAGI recommended the introduction of HPV vaccine in the UIP with a one-time catch-up for 9-14 year adolescent girls followed with routine introduction at 9 years
- Gavi's support to India include:
  - US $116M for new vaccine introductions (procurement of doses) of HPV and TCV.
  - HSS3 new funding envelope includes funding for TA support to introduce HPV vaccine

Support is available to former- and never-Gavi countries through Gavi's MICs Approach to drive new vaccine introductions

Former-Gavi countries yet to introduce HPV *(estimated date of introduction where known)*

- Angola
- Azerbaijan
- Cuba
- Kiribati
- Indonesia (2023)
- Mongolia (2023)
- Nicaragua
- Timor-Leste* (2023)
- Ukraine
- Viet Nam (2026)

Never-Gavi MICs-eligible countries yet to introduce HPV nationwide

- Egypt
- Eswatini
- Iran
- Kosovo
- Occupied Palestinian Territory
- Philippines
- Tunisia

Support available under the MICs Approach for new vaccine introductions

- In-country **technical assistance** from core and expanded partners
- Support for **one-off introduction costs**
- **Vaccine catalytic financing** for half of the first target cohort
- **Former-Gavi countries could access Gavi HPV prices and supply if favorable conditions are agreed with suppliers**

Notes:

- *There are no pre-defined country entitlements under MICs.*
- *Under the MICs Approach there is no support to increase the coverage of already-introduced vaccines*

[12] Note: The June 2022 Gavi Alliance Board approved 'Middle-Income Countries approach' aims to address access issues, including to sustainable pricing, through a range of support modalities and collaborations with UNICEF Supply Division to facilitate pooled procurement mechanisms.

* Support to Timor Leste's HPV introduction is being provided through Post-Transition Engagement

Responsive & catalytic tools: Addressing country-specific needs to **introduce new vaccines**

A suite of targeted and catalytic tools helps drive the **sustainable and equitable introduction of PCV, rotavirus, and HPV vaccines** in both former- and never-Gavi eligible countries:

Technical assistance

Support via relevant core and expanded partners to drive forward sustainable and equitable new vaccine introductions

Flexible funding for one-off costs

Funding to help cover one-off costs related to new vaccine introductions that are traditionally unfunded or challenging to fund

Vaccine catalytic financing

Vaccine financing equivalent to half the first birth (or target) cohort for a new vaccine introduction

Pooled procurement mechanisms

Assistance accessing pooled procurement mechanisms in collaboration with UNICEF Supply Division

National Introduction of HPV Vaccination in Low- and Middle-Income Countries: Lessons Learned from Formal Post Introduction Evaluations (PATH study)

Coverage Data	Vaccination Strategy	Planning	Enabling Environment	Delays in Planning Phase	Training Program	Training Materials	Trainee Knowledge & Appreciation	Communication / Social Mobilization	Community Concerns & Management	Consent	Community Knowledge	Vaccine Delivery	Coverage Disparities	Out-of-School Girls	Drop-out	Reporting & Data Management	Supervisions	Financing
2%	Average	No Data	Challenge	Challenge	Average	Success	Average	Average	Challenge	Challenge	No Data	Average	Challenge	No Data	No Data	Average	Average	Challenge
11%	Average	Challenge	Average	Success	Average	Success	Average	Challenge	Average	Challenge	Average	Average	Challenge	No Data	No Data	Success	Average	No Data
25%	Success	Average	Success	Success	Success	Average	Average	Success	Success	Average	Average	Average	Average	Average	Average	Average	Average	Average
30%	Average	Challenge	Average	Challenge	Challenge	Success	Challenge	Challenge	Average	Average	Challenge	Challenge	Challenge	Challenge	Challenge	Average	Average	Challenge
33%	Average	Average	Success	Average	Challenge	Average	Challenge	Success	Success	Challenge	Challenge	Success	Challenge	No Data	No Data	Success	Average	Average
43%	Success	Success	Average	Success	Success	Success	Average	Success	Average	Average	No Data	Success	Challenge	No Data	No Data	Challenge	Average	Challenge
65%	Average	Success	Success	Challenge	Success	Challenge	Challenge	Average	Success	Success	No Data	Average	Challenge	Challenge	No Data	Average	Challenge	Average
66%	Average	Challenge	Challenge	Challenge	Challenge	No Data	Average	Challenge	Challenge	Average	No Data	Success	Challenge	No Data	Success	Challenge	Challenge	Average
67%	Success	Success	Success	Challenge	Success	Success	Success	Average	Success	No Data	Success	Average	Success	Average	No Data	Challenge	Success	Challenge
67%	Success	Success	No Data	Challenge	Challenge	Success	Average	Average	Challenge	Challenge	Average	Average	Challenge	Challenge	No Data	Challenge	Challenge	Average
70%	Average	Success	Success	Success	Average	No Data	Average	Success	Success	No Data	Success	Average	Success	Success	Average	Success	Success	Average
88%	Average	Success	Success	Average	Success	Average	Average	Success	Success	Challenge	Success	Challenge	Success	Challenge	Average	Success	Average	Challenge
88%	Challenge	Average	Success	Success	No Data	No Data	No Data	Average	Success	No Data	No Data	Average	No Data	Challenge	No Data	Average	Success	No Data
88%	Average	Success	Success	Success	Average	Success	No Data	Challenge	Success	Success	No Data	Success	Success	No Data	No Data	No Data	Challenge	No Data
89%	Average	Average	Success	No Data	Success	Average	Success	Success	Average	No Data	No Data	Average	Success	Challenge	Average	Average	Success	No Data
93%	Average	Success	Success	Challenge	Average	Average	Average	Average	Challenge	Challenge	Average	Average	Challenge	Challenge	Success	Success	Success	Challenge
95%	Success	Success	Success	Challenge	Success	Success	Average	Success	Success	Average	Success	Success	Success	Average	Success	Success	Success	Average

Link here

HPV Implementation: lessons learned

Success factors for good coverage

- Good microplanning at all levels
- Strong political commitment, made visible
- School-based delivery, often integrated with existing structures
- Strong coordination between MOH and MOE at all levels
- All key actors trained (health and education sectors)
- Advocacy via highly visible channels
- Wide variety of communication activities
- Launch events at national and local levels
- Timely implementation of crisis communication plan

Challenges to avoid

- Funding constraints (underbudgeted activities, delay in funds transfer to lower levels)
- Delays in vaccine procurement
- Delays in planning, poor planning, rushed planning
- Infrequent supportive supervision provided
- Poor implementation of communication activities prior to launch
- Lack of informing communities of HPV vaccine and programme prior to introduction
- Training activities did not include school staff
- Lack of coordination between health and education sectors, especially at local level

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Reference: HPV post-introduction evaluation experiences (PATH & WHO) link here


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Thank you