Application Form for Human Papillomavirus Vaccine (HPV) Demonstration Programme

Deadlines for submission of application:
15 January 2016
1 May 2016
9 September 2016

Submitted by:

The Government of Republic of Moldova

Date of submission: September 9, 2016

Form revised in 2015
(To be used with Guidelines of October 2015)

The application form and attachments must be submitted in English, French, Portuguese, Spanish, or Russian.

Please ensure that the application has been received by the Gavi Secretariat on or before the day of the deadline.

SUMMARY TABLE

Component	Country information
Date of introduction	*October 2017*
Target population	*15,000*
Number of districts	*35 + 2 municipalities (excluding Transnistria)*
Vaccine preference	*Gardasil quadrivalent (Merck)*
Total Budget (Year 1 + Year 2) requested from Gavi	*$203,000*
Total costs to be covered by country and/ or other partner resources	*$190,000*
Estimated date of national introduction	*October 2017*
Programme manager/ coordinator	*Rodica Scutelnic,* *State Secretary,* *Ministry of Health*

1. APPLICATION SPECIFICATION

1a. Application specification

Please specify vaccine preference.

Preferred vaccine Bivalent (GSK) or Quadrivalent (Merck) See below for more information	Month and year of first vaccination	Preferred second presentation[1]
Quadrivalent (Merck)	*October 2017*	

[1] This "**Preferred second presentation**" will be used in case there is no supply available for the preferred presentation of the selected vaccine ("**Vaccine**" column). If left blank, it will be assumed that the country will prefer waiting until the selected vaccine becomes available.

1b. Application specification

Please summarise the rationale for choice of preferred vaccine. Also, please clarify whether the vaccine is licensed for use in the country

We have chosen quadrivalent vaccine because it includes two additional HPV types (6 and 11) that prevent genital warts, the price of quadrivalent vaccine offered by GAVI is slightly lower than bivalent vaccine, and it is supplied in single-dose vials which will help to reduce the wastage rate. The quadrivalent vaccine is licensed in the country for use in single-dose vials, and the vaccine has been used previously in the country.

For more information on WHO prequalified vaccines:
www.who.int/immunization_standards/vaccine_quality/PQ_vaccine_list_en/en/index.html

2. EXECUTIVE SUMMARY

2. Executive Summary

Please summarise the rationale and the expected outcome of the HPV vaccination demonstration programme Plan.

[Type text]

In Republic of Moldova, cervical cancer is responsible for a considerable amount of disease and death every year. According to figures from Globocan 2012, cervical cancer is the third-most common cancer in women in Moldova in terms of incidence, mortality and five-year prevalence. In 2012 the estimated

incidence of cervical cancer was 19.6 per 100,000 women (Globocan), the morality rate from cervical cancer was 7.9 per 100,000 women, and the 5-year prevalence of cervical cancer was estimated at 106.5 per 100,000 women (Globaocan, 2012). According the data of the Institute of Oncology in Moldova every day is detected a new case of cancer of the cervix, and every two days a woman dying from cervical cancer. Because more than two-thirds of cervical cancers are caused by HPV, and because HPV infection is most common in people in their late teens and early 20s, Republic of Moldova is very interested in introducing HPV vaccine in young girls. In addition, screening for cervical cancer is quite limited in Moldova, and therefore early vaccination with HPV in Moldova is particularly important.

Moldova's National immunization Technical Advisory Group has recommended the Ministry of Health to include HPV vaccination into national immunization programme. The recommendations were based on consideration of the public health importance of cervical cancer in the country, data on efficacy, effectiveness and safety of HPV vaccines, and preliminary data on the impact of HPV vaccine from countries that introduced this vaccine earlier. However, there are many questions about the best communications strategies and delivery strategies for HPV vaccine in Moldova, particularly in light of differences in attitudes to vaccination among different communities in the country, including vaccine hesitant populations in urban areas, different religious communities, and different ethnic groups. One of the major anticipated obstacles is public concerns about HPV vaccine safety. Rumours about HPV vaccine AEFIs are common in the country; when Moldova received nearly 20,000 doses of donated HPV vaccines from 2010-2012, although nearly all the vaccine was used in the target 10-14 year-old population, many urban residents were sceptical of the vaccine. In addition, this two-dose vaccine poses new challenges for vaccine delivery in an age group that normally does not receive any routine vaccinations. For this reason, the NITAG recommended the MoH to implement HPV demonstration programme and use an opportunity of GAVI support. The Ministry of Health has decided to submit this application to support a vaccination demonstration programme, with the goal of considering national implementation of HPV vaccine once important questions have been answered through the vaccine demonstration programme.

Moldova has decided to target 10 year-old girls for HPV vaccination based on WHO recommendations and programmatic considerations. The Ministry of Health plans to implement the HPV Demonstration programme in the 37 regions that represent entire territory of the country, with the exception of Transnitria region. The population of 10-year-old girls in these districts is roughly the same size as the maximum population allowed for the HPV demonstration programme. 17,400 10-year-old girls reside in the 37 regions. The Ministry of Health plans to use HPV vaccine provided by GAVI to vaccinate 15,000 of 10-year old girls and procure additional doses of vaccine to vaccinate the remaining 2,400 girls in the Year 1 and Year 2, respectively.

Moldova is not applying for the nation-wide introduction because the MoH would like to assess acceptance of HPV vaccine among teenage girls, their parents, and medical workers and develop and pilot an effective communication strategies tailored to different communities prior to inclusion of HPV vaccine into routine immunization programme. The demonstration project will offer the opportunity to conduct a study to learn more about attitude towards HPV vaccine in different populations and develop effective tailored communication strategies, messages, and materials which are crucial for smooth introduction of HPV vaccine.

Another reason to apply for the HPV demonstration project is the need to pilot and select the most appropriate HPV vaccine delivery strategy. Moldova has some experience in providing routine vaccination to age groups beyond infancy. The second dose of MMR is routinely administered to 7 year-old children, and high coverage (95%) was reported in 2015. However, HPV vaccination requires a 2-dose schedule, and the target group is 10-year old girls. In addition, Moldova is home to many children of parents who have left the country. Roughly 400,000 adults are living abroad for work, a situation which has the potential to complicate the logistical situation of parents bringing school-aged children for vaccination.

Vaccine delivery strategy

Vaccination of teenage girls will be organized in primary health care facilities in all 37 regions. The health care facilities will provide vaccination. Healthcare facilities will record immunizations. Although the number of girls who do not attend school in Moldova is minimal, healthcare facility staff will be responsible for identifying out-of-school girls, inviting them for vaccination, and recalling those who did not come for vaccination in time. The health facility staff will also be responsible for communicating the risks of disease and benefits of vaccination with the families of out-of-school girls.

The GPs and vaccinators from health care facilities will be responsible for development of name-based lists of teenage girls to be vaccinated in the current calendar year. They will work with communities to inform teenage girls and their parents about HPV vaccination and vaccination days. The health facility staff will be responsible for vaccinating girls. Health facility staff will also be responsible for recalling girls that did not come for vaccination.

At the end of the demonstration project delivery strategy will be evaluated. The most effective approaches will be selected for a national wide implementation.

Possible barriers in achieving high coverage with HPV vaccine in Moldova

Moldova may confront vaccine safety concerns among girls, their parents, healthcare workers and the public in general. We also anticipate the possibility of clusters of anxiety-related Adverse Events Following Immunization (AEFIs). While we did not witness AEFIs during the delivery of donated HPV vaccine in 2010-2012, there was scepticism and vaccine hesitancy from the public and healthcare workers, including doctors. Outside of Moldova, other middle-income countries of WHO European Region have encountered significant hesitancy. Since 2009 only three middle-income countries have introduced HPV vaccine: Romania, The former Yugoslav Republic of Macedonia (MKD), and Kazakhstan. Although all these countries implemented communication and social mobilisation activities prior to the administration of vaccine, there was low acceptance of HPV vaccine among the public and members of medical societies. Rumours about negative effects of vaccination on teenage girls' health and scepticism about benefits of HPV vaccination flooded the Internet and social media. As a result, the MoH of Romania had to cancel HPV vaccination and destroy the vaccine that it had procured. In MKD the HPV vaccine coverage was much lower than coverage for other teenage vaccines. In Kazakhstan HPV vaccine caused clusters of anxiety-related adverse events following immunization which later transformed into widespread psychogenic / hysteria reactions that created very negative publicity. As a result the MoH of Kazakhstan had to cancel its HPV vaccination program and destroy its vaccine. Recently Denmark and Ireland, high income countries of our region, had similar clusters of anxiety-related AEFIs that negatively affected previously successful HPV vaccination programmes. In Denmark the HPV coverage dropped from 86% to 15% within one year. Another example, is the cluster of anxiety related AEFIs reported in Japan that lead to suspension of HPV vaccination in this country. The information about vaccine safety events in Kazakhstan, Denmark, and Japan has been broadly disseminated through the Internet, mass media, and social media in all countries of the Region. In Moldova, at the regional and national level, the MoH has undertaken continuing efforts to establish the trust of the public and parts of the medical community in HPV vaccination, particularly after the experience with the donated vaccine in 2010-2012; however, many medical workers and parents still have concerns about safety of HPV vaccine.

Development of tailored communication plans for sensitising and mobilising communities

In light of likely concerns about the safety of HPV vaccine among the public and medical personnel, the MoH would like to learn from the demonstration project to identify the most appropriate communication strategies to address these concerns. The experience from countries that introduced HPV vaccine

earlier, suggests that traditional communication strategies used by immunization programmes may not be sufficient. Moldova had a similar experience during the use of donated HPV vaccine in 2010-2012.

We hope to use the demonstration project to help identify innovative approaches to address HPV vaccine hesitancy in Moldova. The National Immunization Program, in collaboration with WHO, will conduct context-specific formative research to better understand barriers and enablers to HPV vaccination including knowledge, attitude, practice and belief towards HPV vaccine. The goal of this research will be to develop communications programs that are specific to the needs of the population.

Based on the results of the research, tailored approaches will be developed, including:

- Identifying the main target audience
- Developing tailored messages and communications material and activities on cervical cancer, HPV infections, and HPV vaccine,
- Identifying the most relevant and sufficient distribution and communications channels

The communication strategies will be defined based on the results of formative research. However, the NIP will likely use different approaches in urban and rural regions. In Chisinau and other urban regions, there is more vaccine hesitancy compared to rural areas, and we anticipate that this will be reflected in the results of our research.

We anticipate that in urban areas the influence of the Internet and social media will be more significant, whereas in rural areas the main sources of information about HPV vaccine may be mass media and local medical workers. We expect that throughout the country religious leaders will play an important role in ensuring high acceptance of HPV vaccine in rural settings. Therefore effective communication packages for rural regions could involve religious leaders.

In summary, we expect that the demonstration project will help to develop, pilot, and evaluate a communication strategies to ensure that HPV vaccine will be well accepted by the population and medical workers in different parts of the country from different backgrounds. In addition, we hope that the demonstration project will help us identify and tailor the most appropriate HPV vaccine delivery strategies. We believe that successful implementation of HPV demonstration project, with the involvement from all relevant stakeholders, will help the MoH make a final decision on inclusion of HPV vaccine into the routine immunization program in Moldova.

3. IMMUNISATION PROGRAMME DATA

3. Immunisation programme data

Please provide national coverage estimates for DTP3 for the two most recent years from the WHO/UNICEF Joint Reporting Form in the table below. If other national surveys of DPT3 coverage have been conducted, these can also be provided in the table below.

Trends of national DTP3 coverage (percentage)				
Vaccine	Reported		Survey	
Year	*2014*	*2015*	*2012 MICS4*	*2005 DHS*
DTP 3	*91.7%*	*91.1%*	*93.3 %*	*89.9 %*
MMR2	*95.2%*	*95.6%*		

*National immunization data, excluding Transnistria

4. Immunisation programme data

If survey data is included in the table above, please indicate the years the surveys were conducted, the

full title, and if available the age groups the data refer to.

***Note:** The IRC may review previous applications to Gavi for a general history of a country's capacities and challenges.*

Not applicable.

4. HPV VACCINATION DEMONSTRATION PROGRAMME PLAN

4.1 District(s) profile

4.2

5. District(s) profile

Please describe which district or districts have been selected for the HPV vaccination demonstration programme, completing all components listed in the table below. Also, kindly provide a district level map of the country.

For further information on factors to consider when selecting the districts, please refer to Annex 2 of the HPV Demonstration Programme Guidelines.

Component	2 urban regions, including Chisinau		35 rural regions	
	Statistic	Data Source	Statistic	Data Source
Topography (% urban, % semi-urban, % rural, % remote, etc.)	*Urban – 91.8% Rural-8.2%*	*National Health Management Center, from National Bureau of Statistics, 2016*	*Urban – 24.2% Rural – 75.8%*	*National Health Management Center, from National Bureau of Statistics, 2016*
Number and type of administrative subunits, e.g., counties, towns, wards, villages	*2 municipality*	*National Immunization Program, 2016*	*1214* towns, wards, villages	*National Immunization Program, 2016*
Total population	*964.886*	*National Health Management Center, from National Bureau of Statistics, 2016*	*2.588.170*	*National Health Management Center, from National Bureau of Statistics, 2016*
Total female population (%)	*521.158 (54.0%)*	*National Immunization Program, 2016*	*1.222.136 (47.2%0*	*National Immunization Program, 2016*

Total female population aged 9-13 years by age (% of total female population) **9 years** **10 years** **11 years** **12 years** **13 years**	*Total female population aged 9-13 years – 21382 (4.1% of total female population)* *9 years-4.897 (0.94%)* *10 years – 4.591 (0.88%)* *11 years – 4464 (0.88%)* *12 years – 3.854 (0.74%)* *13 years – 3.576 (0.68%)*	*National Immunization Program, 2016*	*Total female population aged 9-13 years – 63283 (5.2% of total female population)* *9 years-12.704 (1.04%)* *10 years – 12.819 (1.05%)* *11 years – 12.799 (1.05%)* *12 years – 12.492 (1.02%)* *13 years – 12.449 (1.02%)*	*National Immunization Program, 2016*
Number and type of public health facilities	*61* *Primary health care (FDC, HC, FDC)*	*National Immunization Program, 2016*	*1214* *Primary health care (FDC, HC, FDC, MO)*	*National Immunization Program, 2016*
Number and type of health workers in all district public health facilities	*575 family doctors and 778 family doctor's nurses*	*National Health Management Center (www.cnms.md), 2015*	*1150 family doctors and 3835 family doctor's nurses*	*National Health Management Center (www.cnms.md), 2015*
Number and type of private health facilities that provide primary health care under the contract with National Medical Insurance Company	*12*	*National Health Management Center (www.cnms.md), 2015*	*7*	*National Health Management Center (www.cnms.md), 2015*
Number and type of health workers in private health facilities in the district	*Unknown but sufficient number of doctors and nurses is ensured by the contract with National Medical Insurance Company*	*N/A*	*Unknown but sufficient number of doctors and nurses is ensured by the contract with National Medical Insurance Company*	*N/A*
Number and type of public and private primary and secondary schools	*1323 schools in urban and rural districts (most are public but this number includes all schools)*	National Bureau of Statistics, 2015-2016	*1323 schools in urban and rural districts (most are public but this number includes all schools)*	National Bureau of Statistics, 2015-2016
Estimate the number and percent of girls in school for each of the following ages:9	Data available for all selected regions	National Bureau of Statistics, 2015-2016 &	Data available for all selected regions16.679 (94.8%) 16.360	National Bureau of Statistics, 2015-2016 &

year old girls **10 year old girls** **11 year old girls** **12 year old girls** **13 year old girls**	16.679 (94.8%) 16.360 (94.0%) 16.108 (93.3%) 15.522 (95.0%) 15.487 (96.6%)	*National Immunization Program, 2016*	(94.0%) 16.108 (93.3%) 15.522 (95.0%) 15.487 (96.6%)	*National Immunization Program, 2016*
Estimate the number and percent of girls out of school for each of the following ages in all districts: **9 year old girls** **10 year old girls** **11 year old girls** **12 year old girls** **13 year old girls**	Data available for all selected regions *922 (5.2%)* *1050 (6.0%)* *1155 (6.7%)* *824 (5.0%)* *538 (3.4%)*	*National Immunization Program, 2016*	Data available for all selected regions *922 (5.2%)* *1050 (6.0%)* *1155 (6.7%)* *824 (5.0%)* *538 (3.4%)*	*National Immunization Program, 2016*
Is any routine vaccine currently given to children using schools as delivery points?	*NO* *but the country has routine immunization of 7 year-old children with MMR second dose in health facilities*	*National Immunization Program*	*NO* *but the country has routine immunization of 7 year-old children with MMR second dose in health facilities*	*National Immunization Program*

6. District(s) profile

Please give a brief description of why this district (or districts) was (were) selected to participate in the HPV vaccination demonstration programme.

The Republic of Moldova plans to implement the HPV Demonstration Programme in 37 regions that represent the entire territory of the country, excluding Transnistria, because this will allow us to develop the most effective communications strategies and delivery methods among diverse populations in the country. There are 17,410 10 year-old girls residing in these regions.

We selected two urban regions where we are going to arrange HPV vaccination in health facilities. Currently these urban regions have lower coverage with routine and recently introduced vaccines compared to rural communities; this difference is mainly due to vaccine hesitancy in urban areas. Therefore we expect to encounter higher degree of hesitancy for HPV vaccine in urban regions and plan to develop innovative communication strategies to address them.

Other group is 35 rural regions where we plan to arrange HPV vaccination relying on health care facilities staff only. Although the detailed information about attitude towards vaccination in different sub-population will become available from behavioural study, we expect that in rural setting the religious leaders will have more significant influence on parents' decision to vaccinate their girls. We plan to develop different communication strategies for rural communities to address their specific needs.

Post-hoc analyses of the successes and failures of the demonstration programme will allow us to make a more informed decision about nationwide introduction of the vaccine, and will give us a better understanding of what specific challenges we could face with nationwide introduction.

The NIP is confident that it has sufficient programmatic capacity to conduct the demonstration

project in the 37 regions based on recent successful introductions of infant vaccines (pentavalent, rotavirus, PCV).

7. District(s) profile

Please describe the operations of the EPI programme in the district(s) selected for the HPV vaccination demonstration programme.

Component	2 urban regions, including Chisinau	35 rural regions
Number and type of administrative subunits (e.g. health facilities) used for routine vaccine delivery	*61*	*1214*
Number and type of outreach sessions in a typical month used for routine vaccine delivery	*Vaccinations are offered during specific days of the week in public health facilities; in 2 cities vaccinations are offered two days per week.*	*In the towns vaccinations are offered two days per week and in rural areas vaccinations are offered from once a week to once a month (rural clinics can choose how often to give vaccine based on the target population).*
Polio3 coverage	*90.3% (2015)*	*92.3% (2015)*
MMR-1 coverage at age 1	*87.3% (2015)*	*90.6% (2015)*
Pentavalent 3 coverage	*88.7% (2015)*	*91.8% (2015)*
PCV-3	*79.7% (2015)*	*84.6% (2015)*
Rota 2	*70.9% (2015)*	*80.7% (2015)*
MMR+2 coverage at age 7	*95.3% (2015)*	*95.67% (2015)*
TT2+ (pregnant women)	*N/A*	*N/A*

*vaccine coverage information from National Immunization Program, excluding Transnistria

8. District(s) profile

Please summarise the performance of the district EPI programme as reported in any recent evaluation, for example identifying resources available, management, successes, and challenges. If information from a recent effective vaccine management (EVM) assessment is available, please include.

[Type text]

The following summary and list of strengths and challenges were taken from the 2015 Joint Appraisal Report for Moldova:

Immunization program in Moldova remains strong and well-performing: the overall coverage with the routine and new vaccines in 2014 was between 89% and 97%. However, the country has been experiencing declining coverage rates since 2009 for all antigens included in the national immunization schedule. The main reasons for declining coverage are growing scepticism about benefits of vaccination and concerns among medical workers and parents about vaccine safety. Medical specialists and general practitioners provide medical contraindications (most of them – false) against all vaccines to significant proportion of infants, which delays vaccinations.

The most recent post-introduction evaluation of pneumoccal vaccine (PCV-13), from November 2014, highlighted the following findings about the resources, management, successes and challenges of immunization program in selected 37 regions in rolling out PCV-13:

Prior to the start of the PCV introduction, cascade training sessions were held for medical experts and district and health facility staff and PCV materials were distributed. Immunization cards and reporting forms were updated to include PCV. The evaluation found that all health care workers interviewed had been trained prior to the start of the programme but many felt that direct trainings conducted by national level staff would provide higher quality and more detailed information as well as an opportunity to receive answers to questions.

Vaccine coverage was not being estimated at the health facility level and the reasons for children not being vaccinated were not being properly analyzed although the data were available at health facility level. Data on reasons for non-vaccinated children in Chisinau were analyzed and showed that up to 55% of these children were not vaccinated due to medical contraindications (many were false contraindications), up to 10% were not vaccinated due to parental refusals, and up to 7% were not vaccinated due to families moving within and outside of the country.

The healthcare workers interviewed reported no problems administering PCV.

PCV was found to be stored appropriately at all visited storage areas in the field and personnel were monitoring vaccine storage area temperatures in all but one site. Upgrades to the cold chain were made prior to the introduction of the PCV including new refrigerators, vaccine transport containers and LogTags devices.

At all sites visited, vaccines and supplies were stored in good condition. Healthcare workers reported the transport of vaccines worked well and vaccines and injection equipment were supplied as a bundle. Some challenges with vaccine management were inadequate space for vaccine in two sites and the reasons were thought to be related to seasonal influenza vaccine supply. Vaccine wastage rates were not calculated at any of the evaluated sites.

There is no regular schedule for supervisory visits from the national level to the district level. Nearly all of the visited health facilities had received a supervisory visit since the PCV introduction and received written feedback. However, only 43% of the visited district public health centers had received a supervisory visit from the national level.

Healthcare worker knowledge was generally good and vaccines were stored and handled correctly at observed vaccination sessions.

Injection safety and waste management was generally good and auto-disable syringes were being used in visited health facilities and all but one site was disposing of their used syringes in safety boxes. Re-capped needles were not observed and most health facilities had contracts with a waste disposal company to dispose of vaccine waste. One-third of health facilities were burning their vaccine waste in a pit, which is not in compliance with Ministry of Environment requirements.

An AEFI reporting system is in place but there are no standardized guidelines or AEFI investigation form. The NIP also does not have a risk communication plan in place.

PCV was added to brochures for parents prior to the introduction and PCV information was provided via mass media. Of the health facilities visited, 33% reported resistance from the community regarding PCV. The evaluation team noted that some healthcare workers were sceptical and lacked confidence in vaccines.

All visited sites reported that the implementation of PCV was a smooth process. For future vaccine introductions, healthcare workers said more time is needed prior to the introduction and more information on the new vaccine should be provided using mass media. Also, healthcare workers and parents should be further educated in order to improve their confidence in vaccines. More printed materials should be provided to parents and caregivers to improve their access to information about vaccines. Community outreach activities should be expanded.

Recommendations included the following:

Vaccine coverage:

Immunization data analysis - Ensure that vaccine coverage is estimated at the health facility level. Use vaccine coverage data to monitor the immunization system performance at the health facility and district levels

Reasons for non-vaccination- Conduct regular analysis of the reasons for children not being vaccinated at health facilities and if possible at the district level. Use the results of this analysis to plan and implement measures to increase the uptake of vaccines.

Addressing contraindications- Conduct trainings on contraindications and vaccine safety for district and national level healthcare workers. Develop a Ministry of Health order on contraindications that summaries the information about contraindications for all vaccines and authorizes family doctors to make final decisions about vaccination. Request WHO support for conducting these trainings.

False contraindications- Revise the existing clinical case management protocols to remove false contraindications for vaccinations.

Training for future vaccine introductions: The NIP should consider conducting direct trainings in the districts using national level staff rather than using cascade training. Trainings for future vaccine introductions should include more information on true and false contraindications, vaccine efficacy and safety, and the benefits of vaccination.

Cold chain, vaccine management, and waste management: The Ministry of Health waste management strategy should be aligned with the Ministry of Environment requirements; this activity is already in progress. Health facilities should calculate their vaccine wastage factors.

Adverse events following immunization (AEFI): The NIP should develop comprehensive guidelines on AEFI that include standardized protocols for AEFI monitoring, reporting, and investigation and a standardized AEFI investigation form. The guidelines should be distributed to all health facilities and district public health centres. A risk communication plan should also be developed to ensure effective communication management in response to vaccine safety events.

9. District(s) profile

Please describe any current or past linkages the district EPI programme has had with the primary and/or secondary schools or other outreach locations in the district, e.g., going to schools for health education, delivery of vaccinations, fixed routine outreaches (used by the routine immunisation programme), etc.

Moldova has school nurses in urban settings. Nurses routinely verify immunization cards when children come to school.

10. District(s) profile

Please describe the potential challenges to access and deliver HPV vaccinations to girls and the ways in which these challenges will be addressed. For example, special sensitisation activities that will be done to reduce the potential for rumours.

Taking into account challenges in introduction of HPV vaccine in other countries of the Region and acknowledging strong anti-vaccination sentiment (parent and provider hesitancy) in Moldova, we anticipate challenges related to HPV vaccine safety concerns among public and health care professionals. The concerns can be caused by anti-HPV information available in the Internet and can be disseminated via mass media and social networks. Moldova encountered these challenges during

the administration of donated HPV vaccination in 2010-2012.

In order to address these anticipated challenges we plan to develop and implement robust communications strategies prior to the implementation of the HPV Demonstration project. We will conduct focus groups targeting specific groups of interest (girls, parents, teachers, healthcare workers, opinion leaders, and frontline clinicians) in both urban and rural communities. We will tailor the communications strategies to the findings of the focus groups, optimizing messaging for different groups and also tailoring messages for urban and rural communities. The communication strategies piloted and evaluated during the demonstration project will be then revised in accordance to the evaluation results and used for inclusion of HPV vaccine into routine immunization programme.

11. District(s) profile

Please describe any recent studies, evaluations, or summaries of lessons learned related to socio-economic and/or gender barriers to the immunisation programme. If disaggregated vaccine coverage data by sex or wealth quintile is available from the routine immunisation programme, please note them in this section.

Findings from the Multiple Indicator Cluster Survey (MICS) from 2012 demonstrate that there were very minor differences in vaccination coverage by gender or socio-economic status. For one year-children, for OPV-3, 92.6% of males were vaccinated compared to 94.5% of females. For Hepatitis B-3, 92.5% of males were vaccinated compared to 94.9% of girls. Rural vaccination coverage rates were slightly higher than urban coverage rates (97.5% vs. 87.6% for OPV-3, and 89.8% vs. 96.3% for Hepatitis B-3, respectively). Finally, children in the lowest socioeconomic quintile had slightly higher vaccine coverage compared to those in the highest socioeconomic quintile (98.7% vs. 86.4% for OPV-3 and 98.7% vs. 93.7%, respectively).

4.3HPV vaccine delivery strategy

12a. HPV vaccine delivery strategy

Please identify a single year of age (or single grade in school) at the target vaccination cohort within the target population of 9-13 year old girls and provide information below (see HPV Demonstration Programme Guidelines section 3.2). Countries are encouraged to use the comprehensive list of resources on HPV available at www.gavi.org/library/documents/gavi-documents/guidelines-and-forms/hpv-resources/ to understand data sources and methods for estimating the target population in their country.

Note: The total target population for the Gavi HPV vaccination demonstration programme cannot exceed 15,000 girls per year (all districts combined). Please see section 3.2 of the HPV Demonstration Programme Guidelines for exceptions.

Countries should explicitly define the target population and where and how various subpopulations will be reached.

A preliminary estimate of the number of eligible girls in the target population for each district included in the HPV vaccination demonstration programme should be made by consulting district-level data that may be available from the national statistics office, census bureau, Ministry of Education, district health office, and education department at the district level. Countries should seek support from partners if they need assistance in making this estimate.

WHO has produced national level estimates of the 9-13 year old population by single year of age and sex for each member state. WHO, in collaboration with UNESCO, has also produced country profiles of the female 9-13 year old population in-/out-of- school by urban/rural status, and for income quintile

groups. Countries are encouraged to use these estimates, as well, in informing the selection of the target population for the HPV demonstration programme.

In Moldova we will plan to vaccinate 10 year-old girls in 37 regions that represent the entire territory of the country, with the exception of Transnistria. The high quality data on the size of the target population were generated by the Moldova National Bureau of Statistics. In accordance to 2016 estimate, 17,410 10 year-old girls reside in these 37 districts. We hope that our vaccination coverage for HPV will approach the vaccination coverage for MMR-2 dose in 7 year-old children reported in 2015 (95.6%). However, because of the potential for vaccine hesitancy about this new vaccine and the challenges in the administration of two doses in an age group that does not routinely get vaccinated, we realize that the coverage rate may be closer to the coverage for two newer vaccines – Rotavirus-2 (77.7%) and PCV-3 (83.1%). The Ministry of Health plans to use HPV vaccine provided by GAVI to vaccinate 15,000 10 year-old girls in the Year 1 and Year 2, respectively.

The target population will be defined as a one-year birth cohort. In the first year the target group will be girls born for the period from January until December 2007; in the second year the target group will be girls born for the period from January until December 2008. The first dose of HPV vaccine will be delivered in October and the second dose in April. We recognize that some girls may turn 11 by the time of administration of the second dose. However, the single birth cohort will be used as a denominator for the first and the second doses and the second dose will be given to only girls that received the first dose. Therefore we do not anticipate problems with coverage estimate.

Target population	2 urban regions, including Chisinau		35 rural regions	
Who are the girls eligible for HPV vaccine based on the criteria set by the programme?	Total eligible Year 1	Total eligible Year 2	Total eligible Year 1	Total eligible Year 2
1 Cohort of girls who were born in 2007	N = 4,591	N = 4,360	N = 12,819	N = 12,178
2. Cohort of girls who were born in 2008	N = 4,897	N = 4,652	N = 12,704	N = 12,068
TOTAL	**9,488**	**9,012**	**25,523**	**24,246**

12b. HPV vaccine delivery strategy

Please describe the rationale for the choice of the target population.

[Type text]

We have selected 10-year-old girls because we believe that girls in Moldova do not generally become sexually active until they are older than 10-years old. HPV vaccination will be conducted in primary health care facilities. Finally, this age group was recommended as a target group for HPV vaccination by WHO (girls between the ages of 9 and 13 years old).

13. HPV vaccine delivery strategy

Please describe the delivery strategies that will be used to reach the target population in each district of the HPV vaccination demonstration program. Countries should explicitly define the target population and the delivery strategy that will be used for vaccination.

Moldova plans to build on the existing vaccine delivery system for routine childhood vaccine to deliver HPV vaccine. The current system provides MMR booster dose to 7-year old children and demonstrated its effectiveness in achieving high coverage rates – 96% in 2015. However, the HPV will be given to a different age group – 10 year-olds – and it will require two doses. This will likely make it more challenging to achieve high vaccine coverage levels. For this reason, we plan to implement two slightly different HPV vaccine delivery strategies in urban and rural regions.

In all regions vaccination will be arranged in primary health care facilities. Each health facility has a registry of children and teenagers who reside in their catchment area, including 10 year-old girls. In urban regions each doctor has a catchment area of roughly 1500 people, and each doctor has an enrollment list that is updated annually. Health care facilities will be working directly with the families of 10 years old girls. They will invite girls and their parents for vaccination by phone call or household visit and will follow up with those who did not come for vaccination in time by visiting the family again. The health facilities staff will discuss the risks of the diseases and benefits of vaccination with vaccine hesitant families.

Please complete the table below for each district in the HPV vaccination demonstration programme. An example for illustrative purposes only is provided below.

Target age or grade	Year 1			Year 2		
Who are the eligible girls?	N. of girls	Delivery strategy	Who are the eligible girls?	N. of girls	Delivery strategy	Who are the eligible girls?
1. 10-year-old girls in two urban regions	4,591	***Primary health care facilities in collaboration with school nurses***	***10 year old girls in 2 urban regions***	4,897	***Primary health care facilities in collaboration with school nurses***	***10 year old girls in 2 urban regions***
2. 10-year-old girls in 35 rural regions	12,819	***Primary health care facilities***	***10 year old girls in 35 rural regions***	12,704	***Primary health care facilities***	***10 year old girls in 35 rural regions***
TOTAL	***17,410***			***16,601***		

EXAMPLE: *This may assist in defining which strategy will be used to deliver HPV vaccine with which proportion of the target population.*

Countries are encouraged to use resource materials available in Annex A to learn what has been done elsewhere, and discuss and carefully select the delivery strategies that would work best in their local context.

Target age or grade	Year 1		Year 2	
Who are the eligible girls?	N. of girls	Delivery strategy	Who are the eligible girls?	N. of girls
All girls attending primary school grade 5	3,000	At schools	3,300	At schools
All 10 year old girls who are not attending school at all.	250	Through mobile outreach by health workers	275	Through mobile outreach by health workers
All 10 year old girls who live in hard-to-reach villages in the mountains	500	At villages' health centre	550	At villages' health centre
TOTAL	3,750		4,125	

14. HPV vaccine delivery strategy

Please describe the mechanism or strategy for reaching all the target girls with two doses[1] who were missed on the main vaccination days, specifying plans for reaching hard-to-reach or marginalized girls.

The health care facilities in Moldova have registers of all 10 year-old girls in their catchment area which include school and out-of-school children and teenagers. Health facilities staff will be responsible for following up with families of girls who did not come for vaccination in time. They will visit the family and discuss risks of diseases and benefits of vaccination with vaccine hesitant families.

In both urban and rural regions primary health care facilities will be responsible for following up girls who were invited but did not come for vaccination. The families of these girls will be visited by medical worker.

Based on the findings from the 2012 MICS, there are not large differences in vaccination rates by gender, or socioeconomic status; however the coverage rates of children from urban communities are lower than coverage of children form rural settings. The main reason of this difference is high level of vaccine hesitancy among urban populations and high proportion of missed opportunities to vaccinated infants due to false contraindications in urban health care facilities.

The NIP plans to conduct a KAPB study to better understand the reasons of vaccine hesitancy in urban populations and develop innovative communication strategies to address them. We also plan to continue educations of health care professionals on vaccine safety and contraindications against vaccination.

[1] *NB: Three doses are required only for those known to be immunocompromised.*

15a. HPV vaccine delivery strategy

Please provide a description of the process currently used to obtain (parental or guardian) consent for other vaccines given to adolescents, e.g., meningitis, hepatitis, measles, or other vaccines. Please specify whether there are any specific legal requirements for parental/guardian consent for vaccinations given to the same age group targeted for HPV vaccine delivery.

Currently Moldova requires oral parental consent for all childhood vaccinations. Parents come to health facility together with their children to give their oral agreement for vaccination. In case of refusal form vaccination, parents have to fill out and sign a refusal form.

15b. HPV vaccine delivery strategy

Please describe the consenting procedure that will be used for HPV vaccine delivery. Specify how the parents or guardians will be informed about HPV vaccination and how they can express their willingness to allow their daughters/girls to be vaccinated or not.

The NIP plans to add HPV vaccine into the existing childhood immunization programme; therefore the same parental consent procedure will be used for HPV vaccination. Parents will be informed about introduction of HPV vaccine and planned dates of administration of the first and the second doses of HPV vaccine. They will have an opportunity to receive comprehensive information about the HPV diseases and vaccines and make informed decisions on vaccination of their daughters. If some parents decide not to vaccinate their daughters, they will have an opportunity to inform the GPs from health care facilities which will follow up with these parents to ensure that they understand the risks and benefits of HPV vaccination. If the parents do not change their decision their children will not be vaccinated.

In case they decide not to vaccinate their girls they will have to fill out and sign a refusal form.

The NIP will implement comprehensive communication and social mobilization activities prior to the introduction of HPV vaccine to inform the teenage girls, their parents, and the public about cervical cancer burden and benefits of vaccination and to create demand for vaccination.

16. HPV vaccine delivery strategy

Please summarise ability to manage all the technical elements which are common to any new vaccine introduction, e.g. cold chain equipment and logistics, waste management, vehicles and transportation, adverse events following immunization (AEFIs), surveillance, and monitoring, noting past experience with new vaccine introductions (such as rotavirus, pneumococcal vaccine, or others).

Moldova had very positive experiences with introduction of three new vaccines - pentavalent, rotavirus, and PCV. The post-introduction evaluations demonstrated smooth introductions and confirmed high coverage rates achieved shortly after the introductions. The NIP has effectively managed the technical elements of new vaccines delivery. The findings from the November 2014 Post-Introductive Evaluation for PCV are presented below:

PCV was found to be stored appropriately at all visited storage areas in the field and staff were monitoring vaccine storage area temperatures in all but one site. Upgrades to the cold chain were made prior to the introduction of the PCV including new refrigerators, vaccine transport containers and refrigerator log tags.

At all sites visited, vaccines and supplies were stored in good condition. Healthcare workers reported the transport of vaccines worked well and vaccines and injection equipment were supplied as a bundle. Some challenges with vaccine management were inadequate space for vaccine in two sites and the reasons were thought to be related to seasonal influenza vaccine supply. Vaccine wastage rates were not calculated at any of the evaluated sites.

There is no regular schedule for supervisory visits from the national level to the district level. Nearly all of the visited health facilities had received a supervisory visit since the PCV introduction and received written feedback. However, only 43% of the visited district public health centers had received a supervisory visit from the national level.

Healthcare worker knowledge was generally good and vaccines were stored and handled correctly at observed vaccination sessions but during one session the appropriate vaccination technique was not used.

Injection safety and waste management was generally good and auto-disable syringes were being used in visited health facilities and all but one site was disposing of their used syringes in safety boxes. Re-capped needles were not observed and most health facilities had contracts with a waste disposal company to dispose of vaccine waste. One-third of health facilities were burning their vaccine waste in a pit, which is not in compliance with Ministry of Environment requirements.

An AEFI (adverse events following immunization) reporting system is in place but there are no standardized guidelines or AEFI investigation form.

17a HPV vaccine delivery strategy

Please describe the cold chain status for the selected district and the data source(s) for this information. Information such as the number of cold storage facilities, function and working order of the facilities, storage capacity (and any excess capacity), distribution mechanism for routine delivery of vaccines, status of vaccine carriers and icepacks (e.g., supply shortages or excesses), and plan for HPV vaccine storage and distribution during the HPV vaccination demonstration programme.

HPV vaccine will be stored and distributed according to the current system for vaccine storage and distribution, which is outlined below, according to reports from the 2014 EVM assessment for Moldova.

In Moldova, in-country vaccine deliveries follow a fixed interval, variable quantity distribution schedule. The central storage unit delivers routine vaccines to district storage units quarterly, and to health facilities in in districts monthly or more often as needed. From national to district level vaccines are transported by autorefrigerator. District delivery of vaccines occurs through the use of insulated thermal vaccine carriers.

There is sufficient storage capacity to accommodate all routine vaccines and HPV vaccine at the national level (at the National Public Health Center), and at the regional levels. (From the EVM assessment, Moldova, 2014).

There are no shortages in cold chain capacity in the entire country.

Freeze-tags freezing monitoring were purchased last year for refrigerators at all healthcare facilities. All facilities have been trained on the use of these devices. In addition, each fridge has a thermometer and a LogTag device for recording temperature.

The national level vaccine store has sufficient cold chain volume to accommodate HPV vaccine for 37 selected regions. There are three cold rooms with the capacity of 17,8 M^3, one reserve cold room with the capacity of 30 m^3, and one autorefrigirator with the capacity of 5 m^3.

Component	2 urban regions, including Chisinau	35 rural regions
Number and type of cold storage facilities	*At municipality level one cold room with the capacity of 5,0 m3, 4 refrigerators R700 with capacity of 700 litres, 4 refrigerators MK304 and one refrigerator VLS400. Each health facility has refrigerator to store vaccines. 71% of them equipped with MK144; the rest have domestic refrigerators.*	*District vaccine stores have 2 or 3 refrigerators MK304 and one refrigerator R700.* *At health care level 68% have one refrigerator MK144 and others have one domestic refrigerator.*
Functioning and working order of the facilities	*All are well functioning*	*All are well functioning*
Storage capacity (any excess)	*The storage capacity is sufficient, including HPV vaccine*	*The storage capacity is sufficient, including HPV vaccine*
Distribution mechanism	*Vaccines are stored in the National Public Health Center storage unit. Vaccines are delivered to every district every 3 months or more often. From national to district level vaccines are transported by autorefrigerator. Storage capacity is sufficient to accommodate HPV vaccine at all levels. Vaccines are delivered to facilities every month by cars in thermal containers (2.8 – 4.0 litters' capacity each). Every district level vaccine store has 3-5 thermal containers with the capacity of 20 litters. Last year fridge-tags were supplied to every health facility, and each refrigirator has a thermometer and a LogTag device for*	*[Type text]*

	recording temperature.	
Number and status of vaccine carriers	*All municipality vaccine stores and all healthcare facilities have sufficient number of vaccine carries, including for HPV vaccine*	*All municipality vaccine stores and all healthcare facilities have sufficient number of vaccine carries, including for HPV vaccine*
Number and status of icepacks (any shortages or excess)	*All municipality vaccine stores and all healthcare facilities have sufficient number of icepacks, including for HPV vaccine*	*All municipality vaccine stores and all healthcare facilities have sufficient number of icepacks, including for HPV vaccine*

17b HPV vaccine delivery strategy

There are currently no shortages in the cold chain capacity.

4.4 HPV vaccine delivery training and community sensitisation & mobilisation plans

18a HPV vaccine delivery training and community sensitisation & mobilisation plans

Please describe plans for training of health workers and others who will be involved in the HPV vaccination demonstration programme.

We will use the same approach in conducting trainings for medical workers on HPV vaccine introduction that were used for the introductions of new childhood vaccines. This approach was proven to be effective in achieving smooth introductions and high new vaccines uptake. First, we will conduct trainings for gynaecologists, oncologists, family doctors, and primary health care physicians at national level. Some of these health care professionals will not administer HPV vaccine but as opinion leaders will influence parents' decisions to vaccinate their children. Therefore the NIP will provide them with comprehensive knowledge about HPV diseases and HPV vaccines to ensure their support to HPV vaccine introduction. We also plan to conduct trainings for educational institutions such as medical and nursing schools.

Then we conduct regional level trainings for family doctors and vaccinators from primary health care facilities. The training materials will be developed with technical support from WHO and will consist of presentations, case studies, and pre and post-training surveys. The training modules will be printed and disseminated among trainees. In addition the HPV introduction guidelines will be developed and disseminated during the trainings.

18b HPV vaccine delivery training and community sensitisation & mobilisation plans

(Optional) *If available, countries may provide additional detail in the table below on training content, role, and framework.*

In addition to training, community sensitization and mobilization strategies and plans will be developed, based on a study on knowledge, attitudes and practices that will be conducted in order to identify optimal messages for each target population.

Who will be trained	Role in vaccine delivery (e.g., sensitisation,	Training content (e.g., basics on cervical cancer, HPV,	Who will provide the training?

	mobilisation, immunisation, supervision, monitoring, etc.)	HPV vaccine, IEC messages, safe injections, AEFI monitoring, etc.)	
Health workers	sensitisation, mobilisation, immunisation, supervision, monitoring	cervical cancer disease burden; efficacy and safety of HPV vaccines, IEC messages, safe injections, AEFI monitoring	*National Public Health Center, Institute of Oncology*
Civil Societies **Media** **Women's Associations** **Youth-Friendly Health Centers**	*Advocates, social mobilization*	basics on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring	*National Public Health Center, Institute of Oncology*
Professional Associations (i.e. National Pediatric Associations, National Cancer Association, etc) including Academic Institutions **Institute of Oncology**	*Advocates, social mobilization, sensitizers*	basics on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring	*National Public Health Center, Institute of Oncology, Medical State University*

19a. HPV vaccine delivery training and community sensitisation & mobilisation plans

Please describe the communication plans for sensitising and mobilising communities (e.g. girls, parents, teachers, health workers, district officials, community groups, etc.) for the HPV vaccination demonstration programme.

The preliminary defined target groups for communication and social mobilization activities are as follows: health workers, parents, teenage girls, teachers, government officials and members of civil societies, and community groups. We will conduct a behavioural research study to better understand their knowledge, attitude, perceptions, and behaviour with regards to cervical cancer and HPV vaccines. We will design our study to be able to understand differences between urban and rural communities in the country. Based on these findings, we will develop tailored communication strategies and develop main communication messages and communication and social mobilization plan. This approach is similar to what we have done for previous new vaccine introduction campaigns and it proved to be successful in ensuring smooth introductions and high vaccine uptake.

We will approach our communications strategy with the following goals for both urban and rural populations:

- Ensure that people understand the benefits and risk of HPV vaccination

- Support trust in vaccine and those who deliver them
- Build population resilience against vaccine safety scares
- Encourage Individuals to seek vaccination
- Build robust programmes that are able to respond to trust-related event

We plan to conduct behavioral analysis research among different key informants to understand barriers and enablers to HPV vaccination. These analyses will help us identify key messages that will be used in our communications plan to sensitize and mobilize communities and other relevant audiences about HPV vaccination. Informants could include health care officials, medical scientists, immunization staff, general practitioners, community leaders, parents and girls, religious leaders, NGOs etc.

This research will be done through focus groups, individual interviews, and community survey and will assess the level of knowledge among members of various groups about cervical cancer, how they perceive causes of and risks factors of cervical cancer, benefits and risks of HPV vaccination, and their understanding of who makes decisions regarding vaccination. In other words, to identify enablers, influencers and barriers that affect the girl's decision of being vaccinated. Based on the results of the behavioral analysis tailored approaches will be developed including:

- Identifying the main target audience
- Develop tailored messages and communications material and activities on cervical cancer, HPV infections, and HPV vaccine,
- Identify the most relevant and sufficient distribution and communications channels

Experts and community members will review and pre-test the materials before finalization. As the NIP does not have sufficient capacity to conduct a behavioral study and to develop tailored communication strategies, we will request technical support from WHO to perform these activities.

We have listed below some examples of potential target audiences, communications messages and materials and channels. The behavioral analysis will form the basis of specific tailored approaches; the main target audience, the messages and the communication channels will vary in the strategies for urban and rural areas.

Example of target audience:

- parents
- teenage girls
- community leaders

Examples of communication channels could be:

- Indirect communication through mass media; TV, radiospots, poster, leaflets, social media etc
- Interpersonal communication in the community, including home visits.
- Communication campaign prior to vaccination sessions.
- Counseling commune health centers.

Examples of communications messages could include:

- basic knowledge of cervical cancer
- causes of cervical cancer and the relationship between HPV and cervical cancer
- specific and non-specific preventive measures
- HPV vaccines including vaccination schedule, vaccination targets, and potential side effects.

In addition, the MOH will design and conduct a series of trainings to ensure that health providers have adequate knowledge about HPV vaccine and cervical cancer. Training of Trainers (TOT) courses focused on communication will be organized at the national level. During these trainings, supportive supervision will be conducted to ensure the quality for trainers and participants.

We will also implement activities to prepare the NIP and all other relevant stakeholders to timely identify and properly address vaccine safety events, including Adverse Events Following Immunizations (AEFIs), HPV vaccine safety allegations, and rumours.

We will use all of our relevant means of communication and social mobilisation to deliver our messages to the selected target groups. We will use all types of media. Social media will be a particular focus of our work, because of its prominent role in Moldova. As a program, we have considerable experience working with social media for routine vaccination activities. We have worked with a television station that promotes public health, and we will involve them. We will also use social media to help promote this campaign. We will do this through the National Public Health Center's Website and through the National Public Health Center's facebook page. There is a point person who is responsible for this work at the Center.

We also plan to conduct a training on contraindications and adverse events following immunizations. The training also will address appropriate responses to different kinds of rumours. We will update the frequently asked questions provided at the National Public Health Center website to address arising rumours and other issues.

19b HPV vaccine delivery training and community sensitisation & mobilisation plans

The communication strategies and plans will be developed based on findings of behavioral study which will be conducted in early 2017 after the proposal is approved by Gavi.

Types of information or materials (e.g., leaflet, poster, banner, handbook, radio announcement, etc.)	**Audience receiving material** (e.g., girls, parents, teachers, health workers, district officials, community groups, etc.)	**Method of delivery** (e.g., parent meetings, radio, info session at school, house visit, etc.)	**Who delivers** (e.g., teachers, health workers, district official, etc.)	**Frequency & Timing** (e.g., daily, weekly, twice before programme starts; day of vaccination, two weeks before programme begins, etc.)
[Type text]	*[Type text]*	*[Type text]*	*[Type text]*	*[Type text]*
[Type text]	*[Type text]*	*[Type text]*	*[Type text]*	*[Type text]*
[Type text]	*[Type text]*	*[Type text]*	*[Type text]*	*[Type text]*

20. HPV vaccine delivery training and community sensitisation & mobilisation plans

Briefly describe any potential barriers or risks to community acceptance and the process or communication plan that might be used to address this. Considerations for rumour management and crisis communication should also be described. Consider briefly describing any positive leverage points that might be beneficial for programme implementation to promote acceptability.

Taking into account challenges in introduction of HPV vaccine in other countries of the region and acknowledging strong anti-vaccination groups in Moldova, we anticipate challenges related to HPV vaccine safety concerns among the public and among health care professionals, particularly in urban areas. These concerns may be caused by anti-HPV information available on the Internet and may be disseminated via mass media and social networks. In order to address these anticipated challenges we plan to develop and implement robust communications strategies prior to the implementation of HPV Demonstration project. We will conduct a knowledge, attitudes and practices study targeting specific groups of interest (girls, parents, teachers, healthcare workers, opinion leaders, including academics, and frontline clinicians). We will tailor the communications strategies to the findings of the study. The communication strategies piloted and evaluated during the demonstration project will be than revised in accordance to the evaluation results and used for inclusion of HPV vaccine into routine immunization programme.

We will develop a communication working group in the MoH which will coordinate implementation of crisis preparedness plan to ensure that the NIP, MoH and all relevant stakeholders are prepared to effectively address and communicate vaccine-safety events. The plan includes a mechanism to monitor the internet, mass media, and social networks in order to timely identify rumours and vaccine safety concerns. The plan also addresses the implementation of relevant communication activities. The plan defines the roles of relevant stakeholders in the communication-related response during a crisis.

Cervical cancer incidence and mortality are high in Moldova and are perceived as a serious public health problem. Health care professionals and the public are well aware of this problem. We will use this as a leverage point, emphasizing the seriousness of the disease and its complications, and highlighting the benefits of vaccination.

4.5 HPV vaccine delivery evaluation

21a. HPV vaccine delivery evaluation

The NIP at the National Public Health Center will conduct HPV vaccine post-introduction evaluation at the end of the first year of the project implementation to assess the feasibility of HPV vaccine delivery, to identify possible errors and correct them in a timely manner, and to develop lessons learned for the ultimate nationwide introduction of HPV vaccine. The NIP has a group of trained experts who conducted PIEs for three new childhood vaccines (pentavalent, rotavirus vaccines and PCV) using standardized WHO methodology. This team of national experts will conduct HPV PIE with WHO support.

The NIP will conduct a community-based coverage survey to validate administratively reported coverage with two doses of HPV vaccine in all targeted districts. The NIP will use WHO HPV Cluster Survey tool adapted to HPV demo programme framework. The NIP does not have experience in conducting coverage survey therefore will request WHO technical support.

After one year of project implementation the NIP will perform a micro-costing analysis to get more accurate estimates of HPV vaccination costs and will revise the cMYP accordingly. The estimate will be conducted using WHO Cervical Cancer Prevention and Control Costing Tool. The cost assessment will be conducted with WHO technical support. Because Moldova's NIP does not have experience with this kind of evaluation, WHO technical support will be requested.

21b. HPV vaccine delivery evaluation

(Optional) *Technical partners (e.g. local WHO, UNICEF, other organisation staff) are sponsored by Gavi to offer assistance to the evaluations of HPV vaccine delivery. Please specify if these expert(s) have been identified (name, title, organization). Technical assistance can be requested through technical partners. Please refer to the Gavi PEF roster (available on the Gavi website) to identify partner TA available to you.*

WHO technical support will be requested to conduct HPV vaccine post-introduction evaluation, community-based coverage survey, and the assessment of the cost of HPV introduction. WHO Regional Office for Europe and WHO Country Office will identify technical specialists and international experts to provide technical support to Moldova.

The MoH of Moldova will also request WHO and UNICEF support in conducting behavioural study, developing tailored communication plans for sensitising and mobilising communities, preparing for HPV vaccine crisis communication, and conducting education of health care professionals. The NIP does not have sufficient capacity to implement these activities without external consultancy support.

4.6 Assessing potential integration of adolescent health interventions

22a. Assessing potential integration of adolescent health interventions

Please summarise the anticipated activities for the assessment of integration of adolescent health interventions, such as planning milestones, stakeholder meetings, process for identifying a lead for this activity, and the process to involve the TAG in this work (see HPV Demonstration Programme Guidelines section 4.1 and Annex 6).

The MoH will establish a coordination committee to assess the feasibility and define adolescent health interventions to be integrated with HPV vaccination. The Committee will consist of diverse leadership, including the Center of Public Health, Division of Mother and Child Health, the Division of Health Promotion, the Division of Chronic Diseases and Injuries, the Child Obesity Survivors Initiative, and Youth-Friendly Health Centers. Paediatricians and primary care physicians will also be involved. The Committee will work in close collaboration with relevant stakeholders, including HPV Technical Advisory Group, WHO, UNICEF. The Committee will assess the feasibility of integration of the following adolescent health interventions: vision screening, nutritional counselling, and reproductive health education.

The joint-delivery of selected adolescent health interventions will be implemented in year two and will be included in the evaluation report to GAVI at the end of year one.

22b. Assessing potential integration of adolescent health interventions

(Optional) *Countries can provide a brief summary below of the current adolescent health services or interventions and health education activities given in the district(s).*

In Moldova, adolescent health is an intersectoral issue. Youth-Friendly Health Centers are currently working with children and adolescents, and are working with children and teachers on life-based skill education.

The Ministry of Education collects data related to physical activity and nutrition, with support from the Division of Chronic Diseases at the Ministry of Health. Awareness activities are conducted in primary

schools, and currently a KAP survey related to healthy lifestyle and physical activities is being conducted in schools. There is also a general strategy for general non-communicable diseases that includes activities related to physical activity and nutrition.

4.7 Development or revision of cancer control or cervical cancer prevention and control strategy

23a. Development or revision of cancer control or cervical cancer prevention and control strategy

Please summarise the planned activities for the development or revisions of a national cervical cancer prevention and control strategy, such as planning milestones, stakeholder meetings, methodology for developing the strategy, process for identifying a lead for this activity, and the process to involve the TAG in this work (see HPV Demonstration Programme Guidelines section 4.1 and Annex 6).

In order to develop a national cervical cancer prevention and control strategy, the MoH plans to establish a working group that includes cytologists, gynecologists, midwifes, oncologists and other relevant personnel to coordinate developments of national comprehensive cervical cancer prevention and control plan which will include HPV vaccination and strengthening of cervical cancer screening.

23b. Development or revision of cancer control or cervical cancer prevention and control strategy

(Optional) *Provide a brief summary of the current cervical cancer prevention and treatment services and implementing agencies in the district selected to implement the HPV vaccination demonstration programme. If available, countries can include information on target populations, delivery structure, and funding sources.*

There is currently no nationally approved plan for cervical cancer prevention and treatment services. PAP smears are administered at the discretion of the physician, and treatment is administered to patients at the Institute of Oncology, a 2,000-bed facility in Chisinau. National health insurance does not support routine PAP smear screening for the population.

4.8 Technical advisory group

24. Technical advisory group

Please identify the membership and terms of reference for the multi-disciplinary technical advisory group established that will develop and guide implementation of the HPV vaccination demonstration programme and list the representatives (at least positions, and ideally names of individuals) and their agencies (see HPV Demonstration Programme Guidelines section 4.1 and Annex 6).

Countries are encouraged to use their ICC (Intersecral Coordination Committee on immunization) or a subset of the ICC as the multi-disciplinary TAG.

The TAG must at least have representatives from the national EPI programme, cervical cancer prevention and control, education, the ICC (if separate from the ICC), representative(s) from adolescent health (if they are represented within the Ministry of Health), and representative(s) from civil society organisation(s) that reach the target population of 9-13 year old girls.

The Ministry of Health will establish a Technical Advisory Group to develop and guide implementation of HPV Vaccine Demonstration Project. The TAG will include representatives

from National CPH, Institute of Oncology, Maternal Health Department of the Ministry of Health, the Chair of the National Immunization Technical Advisory Group, the ICC, oncologists, primary health care physicians from the primary health care facilities,. In addition, because many government staff from the Ministry of Health, will be involved, the TAG will report to the ICC.

[Enter the family name in capital letters]

Agency/Organisation	Name/Title	Area of Representation[1]
National Public Health Center	*FURTUNA NICOLAI*	*Deputy director*
Primary Healthcare Department, Medical and Pharmaceutical State University	*CUROCICHIN GHENADIE*	*Head of department*
Chair, National Immunization Technical Advisory Group	*HOLBAN TIBERIU*	*Head of infection diseases department Medical and Pharmaceutical State University*
Institute of Oncology	*CIOBANU VERONICA*	*Deputy Director Coordinator, Cancer Control National Program*

[1]Area of representation includes cancer control, non-communicable disease, immunisation, adolescent health, reproductive health, maternal or women's health, cervical cancer prevention, nursing association, physicians, health communications, midwives, civil society group, education, etc.

25. Technical advisory group

If known, please indicate who will act as the chair of the technical advisory group.

[Enter the family name in capital letters]

	Name/Title	Agency/Organisation	Area of Representation
Chair of Technical Advisory Group			*[Type text]*

4.9 Programme manager/coordinator

26. Programme manager/ coordinator

List the contact details, position, and agency of the person who has been designated to provide overall coordination for the day-to-day activities of the two-year HPV vaccination demonstration programme, taking note that a technical officer/lead/manager from EPI might be most suitable as a part of their current role and responsibilities.

[Enter the family name in capital letters]

Name	*Rodica Scutelnic*	**Title**	*State Secretary*
Tel no	*+373 22 268871*		
Fax no	*+373 22 268856*	**Agency**	*Ministry of Health*
Email	*rodica.scutelnic@ms.gov.md*	**Address**	*2, V. Alecsandri str., Chisinau, Republic of Moldova*

5. TIMELINE

The HPV vaccination demonstration programme will include immunisation of the cohort of girls in two consecutive years (Figure I). Countries are required to begin vaccinating in the demonstration district(s) within two years of the application.

Figure I. HPV vaccination demonstration programme timeline

<table>
<tr><td></td><td>Planning</td><td colspan="3">Implementation Year 1
(begins first day of dose 1)</td><td colspan="3">Implementation Year 2
(begins at first day of dose 1)</td></tr>
<tr><td>Timing</td><td>Up to 8 months</td><td>Months 1-6</td><td>Months 7-9</td><td>Months 10-12</td><td>Months 1-6</td><td>Months 7-9</td><td>Months 10-12</td></tr>
<tr><td rowspan="3">Activities</td><td rowspan="2">Planning
Training
Supply
Distribution
Sensitisation
Mobilisation

Orientation workshop</td><td rowspan="2">First year of vaccination

PIE at the time of final dose</td><td rowspan="2">Evaluation of Year 1

Coverage survey within 6 weeks of final dose</td><td>Meeting to review Year 1 evaluation and lessons learned

Adjust programme for Year 2

Report of Year 1 to Gavi

If country is ready, prepare application for National support</td><td rowspan="2">Second year of vaccination</td><td rowspan="2"></td><td rowspan="2">Report of Year 2 to Gavi</td></tr>
<tr><td colspan="2">Costing analysis starts after the first dose</td></tr>
<tr><td colspan="3">Assessment of adolescent health interventions</td><td>Incorporate joint delivery in programme for Year 2 (optional)</td><td>If feasible, implement joint delivery of services</td><td>If applicable, evaluate joint delivery - coverage survey & costing study</td><td></td></tr>
<tr><td></td><td colspan="3">Start drafting cervical cancer prevention & control strategy</td><td colspan="2">Completion of draft cervical cancer prevention & control strategy</td><td>Approved Cervical Cancer strategy to Gavi</td></tr>
</table>

27. Timeline

Please draft a chronogram using the Gavi chronogram template for the main activities for HPV vaccination preparations and implementation, assessment of adolescent health interventions, evaluation of the demonstration programme, and development/revision of a national cervical cancer prevention and control strategy.

Please download the Excel chronogram template from the Gavi online country portal, accessible via www.gavi.org, and attach to the application form as Attachment 2.

Countries should ensure enough time is scheduled for planning activities prior to delivery of HPV1. For programme tracking purposes, Year 1 starts with delivery of the first dose of vaccine.

6. BUDGET ATTACH THE BUDGET

28. Budget

Please provide a draft budget for year 1 and year 2, identifying activities to be funded with Gavi's programmatic grant as well as costs to be covered by the country and/or other partner's resources. The budget should include costs for planning and preparations, vaccine implementation, assessment of adolescent health interventions, evaluation of the demonstration programme, and development/revision of a national cervical cancer prevention and control strategy.

Please download the Excel budget template from the Gavi website at: www.gavi.org/support/apply, *and attach to the application form as Attachment 3.*

Note: If there are multiple funding sources for a specific cost category, each source must be identified and their contribution distinguished in the budget.

7. Procurement of HPV vaccines and cash transfer

In the HPV Demonstration programme, HPV vaccines will be provided at no cost to the country and will be procured through UNICEF. Auto-disable syringes and disposal boxes will be provided.

Please note that, using the estimated total for the target population in the district and adding a 10% buffer stock contingency, the Gavi Secretariat will estimate supplies needed for HPV vaccine delivery in each year and communicate it to countries as part of the approval process.

29. Procurement of HPV vaccines and cash transfer

Please indicate how funds for operational costs requested in your budget in section 6 should be transferred by Gavi (if applicable).

We will use the account agreed with Gavi.

8. Fiduciary Management Arrangements Data

30. Fiduciary Management Arrangements Data

Please indicate below whether the grant to partially support the activities of the HPV vaccination demonstration programme is to be transferred to the government, or to WHO or UNICEF. Please note that WHO and/or UNICEF will require administrative fees of approximately 7% and 8% respectively which would need to be covered by the operational funds

If the grant for the HPV vaccination demonstration programme should be transferred to the government, countries which have completed a financial management assessment (FMA) should confirm whether the financial management modalities – including bank details – agreed with Gavi are still applicable, or alternatively provide details of any modification they intend to submit relating to the existing financial management arrangements.

Countries without an FMA, but who would like the grant for the HPV vaccination demonstration programme to the Government, should provide as Attachment 4 a description of their proposed funding mechanism to manage the grant for the HPV demonstration programme, covering the following processes:

1. *Planning, budget and coordination*
2. *Budget execution arrangements including internal controls*
3. *Procurement arrangements*
4. *Accounting and financial reporting*
5. *External audit arrangements*
6. *Internal audit oversight*

The MoH requests GAVI to transfer the grant to partially support the activities of the HPV vaccination demonstration programme to the Ministry of Health using financial management modalities indicated in FMA and agreed with GAVI.

9. SIGNATURES

9.1 Government

31. Signatures

The Government of Republic of Moldova **acknowledges that this Programme is intended to assist the government to determine if and how it could implement HPV vaccine nationwide. If the Demonstration Programme shows that HPV vaccination is feasible (i.e. greater than 50% of a one-year cohort selected from the population of 9-13 year old girls in at least one district and one delivery strategy of the Expanded Programme on Immunisation (EPI)) and sustainable, Gavi will encourage and consider a national application. To ensure continuity, the application should be submitted during the first or second year of the Demonstration Programme. Application forms and guidelines for national applications are available at www.gavi.org/support/apply/. The data from the Demonstration Programme and timing of a national application are intended to allow uninterrupted provision of vaccine.**

The Government of Republic of Moldova would like to expand the existing partnership with Gavi for the improvement the health of adolescent girls in the country, and hereby requests for Gavi support for an HPV vaccination demonstration programme.

The Government of Republic of Moldova commits itself to improving immunisation services on a sustainable basis. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of targeted young adolescent girls with HPV vaccine as outlined in this application.

The Government of Republic of Moldova acknowledges that some activities could be requiring approval by local ethics committees). The Government of Republic of Moldova acknowledges responsibility for consulting and obtaining approval from appropriate local ethics committees

(e.g., human subject protection committee or Institutional Review Boards) in country, as required. By signing this application, the Government of the Republic of Moldova and the TAG members acknowledge that such approval may be necessary and that it will obtain such approval as appropriate.

The table in Attachment 3 of this application shows the amount of support requested from Gavi as well as the Government of Republic of Moldova's financial commitment for the HPV vaccination demonstration programme.

Please note that this application will not be reviewed by Gavi's Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Education or their delegated authority.

32. Signatures

Please provide appropriate signatures below.

[Enter the family name in capital letters]

	Deputy Minister of Health (or delegated authority)		Minister of Education (if social mobilization, vaccination or other activities will occur through schools) (or delegated authority)
Name	*ALIONA SERBULENCO*	**Name**	*[Type text]*
Date	12.10.16	**Date**	
Signature		**Signature**	

33. Signatures

This application has been compiled by:

[Enter the family name in capital letters]

Full Name	Position	Telephone	Email
Anatolie Melnic	*Advisor to the director-Manager, National Immunization Program National Center for Public Health, Moldova*	*373-22-574-674*	*amelnic@cnsp.md*

9.2 National Coordinating Body – Inter-Agency Coordinating Committee (ICC) for Immunisation

34. Signatures

We the members of the ICC, HSCC, or equivalent committee met on *11.10.2016* **to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.**

The endorsed minutes of this meeting are attached as Attachment 1.

[Enter the family name in capital letters]

Name/Title	Agency/Organisation	Signature
SERBULENCO ALIONA	*Deputy Minister MoH*	
PINZARU IURIE	*General director National Center of Public Health (NCPH)*	
MELNIC ANATOLIE	*Head of Center for Immunoprofilaxis NCPH*	
GROSU-AXENTI DIANA	*Deputy girector National Medical Insurance Company*	
SEMENIUC MARINA	*Head of Department financial management in health care and social protection, Ministry of Finance*	
MANGASAREAN NUNE	*Reprezentaive of UNICEF in Republic of Moldova*	
HAJRULAHOVIC HARIS	*Reprezentative of WHO in Republic of Moldova*	
ONEA LILIA	*Representative of civil society*	
ROTARU MIHAIL	*Deputy director, Mother and Child Institute*	

35. Programme manager/ coordinator

In case the GAVI Secretariat has queries on this submission, please contact:

[Enter the family name in capital letters]

Name	*Rodica Scutelnic*	**Title**	State Secretary of the Ministry of Health
Tel no	*+373 22 268871*		
Fax no	*+373 22 268856*	**Address**	2, V. Alecsandri str., mun Chisinau, Republic of Moldova
Email	*rodica.scutelnic@ms.gov.md*		
Mobile no	*+37378284675*		

10. ATTACHMENTS

Attachment 1. Minutes of the Inter-Agency Coordinating Committee meeting endorsing the HPV vaccination demonstration programme application.

Attachment 2. Chronogram for the HPV vaccination demonstration programme.

Attachment 3. Budget and finances for the HPV vaccination demonstration programme.

Attachment 4. Proposed funding mechanism for HPV vaccination demonstration programme. This is required ONLY for countries without an existing FMA and countries currently receiving Gavi direct financial support through a UN agency.

Minutes of meeting

Immunization Inter-agency Coordination Committee meeting

Date: October 11, 2016 **Time:** 09^{00}

Place: Ministry of Health

Chisinau, 2 Vasile Alecsandri str., Meeting Room.

At the meeting were invited 9 members of IICC.

Were present:

1)SERBULENCO ALIONA	**Deputy Minister (MoH)**
2)PÎNZARU IURIE	**General director National Center of Public Health (NCPH).**
3)MELNIC ANATOLIE	**Head of Center for Immunoprofilaxis (NCPH).**
4)GROSU-AXENTI DIANA	**Deputy director National Medical Insurance Company.**
5)SEMENIUC MARINA	**Head of Department financial management in health care and social protection, Ministry of Finance.**
6)MANGASAREAN NUNE	**Representative of UNICEF in Republic of Moldova.**
7)HAJRULAHOVIC HARIS	**Representative of WHO in Republic of Moldova.**
8)ONEA LILIA	**Representative of civil society.**
9)ROTARU MIHAIL	**Deputy director, Mother and Child Institute.**

Meeting Agenda

- Review information and proposal on the implementation of vaccine against human papillomavirus in Republic of Moldova.

In context of review the proposal on implementation of the vaccine against human papillomavirus (HPV) was reviewed aspects of HPV vaccine and general information on cervical cancer due to human papillomavirus.

Human papillomavirus (HPV) is the most common viral infection of the reproductive tract. Cervical cancer is by far the most common HPV-related disease and is the second in the world in frequency of all cancers in women under the age of 45 years and is the second most common cancer in women living in less developed regions.

In Republic of Moldova, cervical cancer is responsible for a considerable amount of disease and death every year. Cervical cancer is the third-most common cancer in women in Moldova in terms of incidence, mortality and five-year prevalence. According the data of the Institute of Oncology in Moldova every day is detected a new case of cancer of the cervix, and every two days a woman is dying from cervical cancer. Cervical cancer presents a major public health problem in Moldova. In "Capacity assessment and recommendations for a national screening program for cervical cancer in Moldova" prepared by Dr. Philip Davies and Dr. Diana Valuta, (Chisinau, February 2014) is emphasized that in Moldova mortality rates due to cervical cancer are very high, 17.2 cases and 7.4 cases to 100,000 women respectively. Republic of Moldova is very interested in introducing HPV vaccine in young girls. In addition, screening for cervical cancer is quite limited in Moldova, and therefore early vaccination with HPV in Moldova is particularly important. Since 2006 the practice of medicine has a cure safe and highly effective in preventing infection with two vaccines that prevent infection which prevent the development of cervical cancer. In 2016 vaccination against human papillomavirus is performed already in 64 countries (33%) and was proven the high cost efficiency and safety of the vaccine at 92-100%.

Republic of Moldova, as a graduate country, can benefit from GAVI support in the implementation of HPV vaccine. GAVI proposes two alternatives for implementation of HPV vaccine:

The first option is nationwide implementation in which GAVI will provide free land 50% of its vaccine for one year, additionally a grant for the implementation of the vaccine for each girl 2.40 US $ in a year. Until 2025, country procurement of HPV vaccine, benefits from GAVI price through UNICEF.

The second option is the so called "Demonstrational program", where the country will be provided with 2 doses of vaccine for 15.000 girls over two years. It also provided a grant for the implementation of the vaccine for 3.60 US $ each girl for two years. Until 2025, country benefits HPV vaccine procurement price through UNICEF. HPV vaccine price for GAVI countries will be 4.5 to 4.6 $ per dose which is 3 times less than prices from market.

However, to qualify GAVI support in one of the proposed options, country should make the request until 13.10.2016. This is the last time and the last chance to get GAVI support in the implementation of HPV vaccine.

National Immunization Program proposed to select demonstrational program by GAVI for implementation. Calculations showed that the amount of vaccine provided by GAVI will be possible in the first two years of vaccination coverage reached of young girls up to 80-85%.

ICCI promotes the importance of implementation of HPV vaccine in Republic of Moldova and proposed to require „Gardasil quadrivalent" vaccine, one of the arguments was that it is packed in one dose/vial, excluding losses. One of the conditions of GAVI is that vaccination must to be started in 2017 and after completion of country assistance to ensure further sustainable vaccination.

Decision:

Members of ICCI approved the implementation of the demonstrational program of vaccination against human papillomavirus proposed by GAVI and recommended to Ministry of Health in implementing the program given for country.

Chairman of ICC - **Aliona SERBULENCO**

Secretary **Antolie MELNIC**

Translated by Alexei Ceban, Tel. +37368505323, email: alexeiceban99@yahoo.com

HPV Introduction Timeline/Work plan of Activities - Republic of Moldova

Key Activities	Planning (January-September 2017)									Implementation Year 1 October 2017 - September 2018)												Implementation Year 2 October 2018 - September 2019)										
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Establish TAG																																	
Draft implementation plan																																	
Orientation workshop with key stakeholders																																	
Conduct behavioral research study; use findings to develop communication strategy and messages																																	
Develop communication plan																																	
Develop HPV vaccination guidelines; review and revise guidelines for immunization practices (vaccine management; AEFI monitoring; immunization recording and reporting)																																	
Double-check cold chain storage capacity at regional facilities and health-facilities according to HPV vaccine storage requirements																																	
Clear vaccine supply from customs																																	
Establish technical group to select adolescent health interventions to be integrated with HPV vaccination																																	
Assess adolescent health interventions and select interventions to be integrated with HPV vaccination in Year 2																																	
Develop training plan																																	
Establish national cervical cancer prevention and control working group with TAG in collaboration with the MoH working group, finalize national cervical cancer prevention and control strategy																																	
Conduct national and regional trainings according to the training plan																																	
Conduct microplanning at regional and health facility levels																																	
Implement communication plan and ocontinue building capacity for crisis communication																																	
Transport vaccine to regions and health facilities																																	
Implement year 1 vaccination round																																	
Follow up vaccination of girls who missed vaccination days																																	
Conduct coverage survey																																	
Collect cost assessment data																																	
Conduct cost analysis																																	
Conduct post-Introduction evaluation																																	
Select adolescent interventions to be integrate with HPV vaccine action in Year 2																																	
Review results from year 1 and outline any programme delivery changes for year 2, including whether to do joint delivery of HPV vaccine and adolescent health intervention																																	
Conduct year 1 review meeting; adapt year 2 delivery and communication strategies, if required; make a decision on integrated delivery of selected adolescent health interventions																																	
Develop and submit Year 1 report to GAVI																																	
Refresher training for medical workers																																	
Implement year 2 vaccination round integrated with selected adolescent health interventions																																	
Follow up vaccination of girls who missed vaccination days																																	
Conduct coverage survey (if the delivery strategies were changed, including joint delivery)																																	
Conduct costing analysis (if the delivery strategies were changed, including joint delivery)																																	
Conduct TAG review meeting with participation of key stakeholders																																	
Final recommendations to MOH for inclusion of HPV vaccine into routine immunization schedule, including recommendations on vaccine delivery (joint with other adolescent interventions) and communication strategies																																	
Develop and submit Year 2 report to GAVI																																	

Vaccine Introduction Grant of HPV

Table as the Application Forms for cost and financing of vaccine introduction or campaign in US$

Country Republic of Moldova

Target Population size: 15 000

Please provide further details for each cost category using the subsequent detailed tables. The totals for cost categories in the summary table should match the detailed disaggregated cost category totals.

	Cost Category	TOTAL COST (US$)	Funding Source					
			Government Year 1 (US$)	Government Year 2 (US$)	Gavi Year 1 (US$)	Gavi Year 2 (US$)	Partners Year 1 (US$)	Partners Year 2 (US$)
1	Task Force meetings (TAG)	4 000	2 700	1 300				
2	Program management and coordination (Planning and preparations)	29 000			20 000	9 000		
3	Community sensitization and mobilization	28 500			8 500	5 000	10 000	5 000
4	Trainings and meetings	47 500			18 000	7 500	12 000	10 000
5	Waste disposal	20 000	10 000	10 000				
6	Cold chain equipment	25 000			10 000	5 000	10 000	
7	Strategy Development	10 000					10 000	
8	Monitoring and Supportive Supervision	20 000	3 300	1700	5 000		8 000	2 000
9	Evaluation and Assessment	189 000	2 700	1300	65 000	30 000	60 000	30 000
10	Personnel, including salary supplements and/or per diems	20 000			13 500	6 500		
11	Technical assistance	-						
	Total (Excluding PSC)	393 000	18 700	14 300	140 000	63 000	110 000	47 000

** If more than one partner is providing financial support to a specific cost category, please list all partners for that category and the amount of support provided.*

Grand total requested by Gavi	**203 000**

MINISTERUL SĂNĂTĂȚII AL REPUBLICII MOLDOVA

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www.ms.gov.md

13.10.2016 nr. 01-10/750
La nr. _____ din _____

Глобальный Аллианс по Вакцинам и Иммунизации

Приложение 4 к заявке на внедрение
вакцины человеческой папиллома вируса

При реализации Гранта предназначенного для внедрения вакцины человеческой папиллома вируса будет использоваться механизм финансирования, включая следующие процедуры:

1. Планирования осуществляется исходя из объёма выделенных средств и потребностей Министерством здравоохранения с последующим утверждением плана МККИ. При поступлении средств на Казначейский счет Министерство здравоохранения они переводятся в национальную валюту по официальному курсу на день поступления и приобретают статус публичных средств. Для расходования этих средств Министерство здравоохранения, в соответствии с планом, составляет постатейную смету расходов в соответствии с законодательными документами страны. Смета утверждается Министерством здравоохранения и координируются Министерством финансов.
2. Реализация бюджета осуществляется в соответствии с утвержденной сметой расходов.
3. Закупки осуществляется в соответствии с Законом о государственных закупках путем банковских переводов средств на счета поставщиков товаров или услуг. Товары и услуги приобретаются на основании договоров, заключаемых на основании договоров, заключаемых на основании общественных конкурсов предложении или тендеров по общественных закупкам утверждаемых Агентством по государственным закупкам.
4. Средства подлежат бухгалтерскому учету и отчетности в соответствии с законодательством страны.

5. Средства подлежат внешнему аудиту со стороны компетентных контрольно – финансовых страны: Счетная палаты РМ, Финансовая инспекция Минфина, Налоговая инспекция.

Заместитель министра **Алена Сербуленко**