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Application Form

for Country Proposals

*for receiving approximately two years of support for an*

*HPV Demonstration Program*

**Submission Deadline: 15 September 2013**

Submitted by

The Government of the Republic of Mali

Submission Date: 13 September 2013

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**ACRONYMS AND ABBREVIATIONS**

|  |  |  |
| --- | --- | --- |
| **Acronym/Abbreviation** | | **Definition** |
| ComHC | Community Health Center | |
| RefHC | Referral Health Center | |
| HPV | Human Papillomavirus | |
| EPI | Expanded Program on Immunization | |
| RGPH | General Census of Population and Dwellings | |

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Please submit the Proposal using the form provided.

Enquiries to: [proposals@gavialliance.org](mailto:proposals@gavialliance.org?subject=Applications%20for%20New%20Vaccine%20Support) or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public. The Proposal and attachments must be submitted in English, French, Spanish, or Russian.

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

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

**GAVI ALLIANCE**

**GRANT TERMS AND CONDITIONS**

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms. These terms and conditions may also be included in a grant agreement to be agreed upon between GAVI and the country.

***FUNDING USED SOLELY FOR APPROVED PROGRAMS***

The applicant country (“Country”) confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the program(s) described in this application. Any significant change from the approved program(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

***AMENDMENT TO THIS PROPOSAL***

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the program(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

***RETURN OF FUNDS***

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the program(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance. Any funds repaid will be deposited into the account or accounts designated by the GAVI Alliance.

***SUSPENSION/TERMINATION***

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programs described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programs described in this application if a misuse of GAVI Alliance funds is confirmed.

***ANTICORRUPTION***

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

***AUDITS AND RECORDS***

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

***CONFIRMATION OF LEGAL VALIDITY***

The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country’s law, to perform the programs described in this application.

***CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARENCY AND ACCOUNTABILITY POLICY***

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

***ARBITRATION***

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programs described in this application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programs described in this application.

***USE OF COMMERCIAL BANK ACCOUNTS***

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

1. Application Specification

**Q1.** Please specify for which type of GAVI support you would like to apply to.

|  |  |  |
| --- | --- | --- |
| **Preferred vaccine**  **(bivalent (GSK) or quadrivalent (Merck))**  **See below for more information** | **Month and year of first vaccination** | **Preferred second presentation1** |
| Quadrivalent [Merck] | October 2014 | Bivalent [GSK] |

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

In Mali during a multi-center study conducted in 2002, 89.7% of cervical cancers were associated with infection by the Human Papillomavirus (HPV) [[1](#_ENREF_1)]. In this study, the HPV16 strain (34.5%) was the most frequent, followed by the HPV45 strain (17.2%), the HPV18 strain (12.1%) and the HPV31 strain 6.1%) [[1](#_ENREF_1)]. There are currently two types of immunizations which have been licensed for the prevention of cervical cancer in women [2]. The quadrivalent vaccine covers HPV strains 6, 11, 16 and 18 and the bivalent vaccine only covers HPV strains 16 and 18 [[2](#_ENREF_2)]. In addition to its efficiency in preventing cervical cancer, the quadrivalent vaccine protects against anogenital warts and cancers of the vulva and the penis with good clinical tolerance and good immunogenicity [[2](#_ENREF_2), [3](#_ENREF_3)]. Considering its cost effectiveness, [[2](#_ENREF_2)], and the low capacity for controlling and preventing cervical cancer, the quadrivalent vaccine is a good option for a developing country such as Mali.

For more information on vaccines: <http://www.who.int/immunization_standards/vaccine_quality/PQ_vaccine_list_en/en/index.html>

1 This "**preferred second presentation**" will be used if 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 prefers to wait until the selected vaccine becomes available.

1. Executive Summary

**Q2.** Please summarize the rationale and the expected outcome of the HPV Demonstration Program Plan.

Cervical cancer is the leading cancer among women in Mali. In 2008, it was estimated to occur in 27 out of 100,000 women annually [[4](#_ENREF_4)].

Continued growth in morbidity and mortality can be attributed to cervical cancer, making this disease a public health priority in developing countries as well as in developed countries [[1](#_ENREF_1)].

In Mali, as in developing countries, due to the inability to diagnose and care for this disease, morbidity and mortality rates are unknown.

However, the link between HPV infection and the risk of cervical cancer is an established one[[2](#_ENREF_2)]. This is the most frequently sexually transmitted disease in the world [[2](#_ENREF_2), [5](#_ENREF_5)]. It is often asymptomatic in both women and men[[5](#_ENREF_5)]. There are several strains of HPV, but 70 to 80% of cervical cancers are associated with the HPV16 and HPV18 strains [[2](#_ENREF_2)]. In Mali, the situation is marked by a high frequency of HPV 16, 45, 18 and 31) strains [[1](#_ENREF_1)] and a strong prevalence of precancerous lesions and invasive cancer [[6](#_ENREF_6)]. The infection occurs more frequently in rural areas than urban areas [[7](#_ENREF_7)].

Considering the size of the problem, the State of Mali drafted [[8](#_ENREF_8)]a strategic prevention and care plan in 2009 to address cervical cancer. Despite these efforts, a recent multi-centric study on precancerous and cancerous lesions [[9](#_ENREF_9)] in 29,572 women living in an urban environment, reported a 3.2% confirmed cervical cancer rate. This requires that active research activities as well as other preventive measures be intensified. Various teams have already begun clinical research studies. Preliminary work on screening and introducing an HPV vaccine is being implemented within the clinical research unit (CVD-CNAM); the objective is to study the feasibility of introducing the vaccine into the national immunization program.

According to the WHO report, immunization reduces the risk of cancer by 80% in countries which have been able to implement a screening program as well as efficient immunization against HPV [[2](#_ENREF_2)].

Introducing an HPV vaccine will contribute to the reduction of cervical cancer incidence in Mali. As shown by a mathematical simulation model, immunization coverage of 50% would allow for an absolute reduction of prevalence of 19%, and a relative reduction of 49% of the risk of infection by HPV [[8](#_ENREF_8)]. Inspired by this mathematical model, the immunization of girls aged 9 to 13 years in two health districts would contribute to the reducing morbidity and mortality from cervical cancer in Mali.

To implement this phase of the demonstration, the quantities of HPV vaccine will be received and stored at the central level before routing them to the relevant districts. Carried out using the WHO EPI-Forecasting-Tool, the data analysis of the central facility's storage capacity shows that the capacity is sufficient to store the vaccines before they are distributed. There is no need to invest in an expansion for this at the central level.

In the two test districts, there is a **gap** of 216 liters that requires an investment estimated at a value of US$2,228.

Introducing health modules on adolescent reproductive health into socio-health worker training programs will be considered.

The results of this demonstration will allow for the introduction of the HPV vaccine into the Expanded Program on Immunization (EPI) in Mali to be considered.

The GAVI-supported demonstration project for introducing the vaccine to prevent HPV infections in the two health districts, Fana and Commune V, will begin in 2014 and will improve primary prevention of cervical cancer in Mali.

GAVI support for this Human Papillomavirus immunization demonstration will last two years. The total amount of funding is estimated at US$217,919, of which US$183,804 is the grant requested from GAVI. US$34,115 of the total will be used State and its national partners for administrative purposes.

The preferred vaccine for the Human Papillomavirus immunization demonstration is the quadrivalent vaccine. The vaccine will be administered to 10-year-old girls attending school as well as girls who are not attending school, according to the following calendar: month 1 (1st dose HPV1: October), month 3 (2nd dose HPV2: December) and month 7 (3rd dose HPV3: April).

The project is scheduled to begin in October 2014 so that it is in sync with the school year and so that the target is reachable during the school year, significantly reducing wastage.

The cohort of 10-year-old girls in these two districts is estimated to be 12,445; 5,463 of whom are in a school environment. The targeted objective is to reach at least a third-dose coverage for HPV that is greater or equal to 50%; this is the main condition that must be fulfilled for extending this immunization program to the rest of the country.

A mixed approach (school-based as well as community-based) was decided upon for this demonstration. Girls attending school will receive the vaccine at their schools with the support of the teaching staff; girls who are not attending school will be reached using fixed strategies in health centers and outreach strategies in villages / neighborhoods through peer educators, community liaisons and leaders for the census and mobilization of the girls.

During the immunization campaign, there will be 6-day-long immunization sessions held in schools (from Monday to Thursday) and 7-day sessions in health centers, villages and neighborhoods (from Monday to Sunday). In health centers, catch-up sessions will take place the following week.

The key activities that will take place will include information and communication to key stakeholders at the school level and at the community level before, during and after immunization; updating immunization tools; training health workers and teachers; the administration of vaccines within communities and schools; social mobilization; and monitoring and evaluations.

1. Immunization Program Data

**Q3.** 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.

Table I: National Coverage Trends for DTP3 in %

|  |  |  |  |
| --- | --- | --- | --- |
| **Vaccine** | **Reported** | | **Survey** |
|  | 2011 | 2012 | 2010 |
| Penta 3 | **88 %** | **91.9%** | **75 %** |

**Q4.** 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.

Evaluation of immunization coverage for routine EPI took place in 2010. This addressed the age range from 12-23 months and mothers of children under 1 year of age.

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

1. HPV Demonstration Program Plan

4.1 District(s) Profile

**Q5.** Please describe which district or districts have been selected for the HPV Demonstration Program, completing all components listed in the table below. Also, kindly provide a district level map of the country.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Figure 1 :** Map of the Republic of Mali |  | | **Figure 2 :** Map of Fana Health District | |  | |  | **Figure 3 :** Map of Commune V Health District in Bamako District | |

Table II: Profile of selected districts (Fana and Commune V).

| **Component** | **District 1: Fana** | **District 2: Commune V in Bamako District** |
| --- | --- | --- |
| Topography (% urban, % semi-urban, % rural, % remote, etc.) | 25% Semi-urban  75% Rural | 100% Urban |
| Number and type of administrative subunits, e.g., counties, towns, wards, villages | 3 Arrondissements  13 Rural municipalities  224 Villages | 1 Urban municipality made up of 8 neighborhoods |
| Total population | 269,563 Inhabitants [[10](#_ENREF_10)] | 494,409 Inhabitants [[10](#_ENREF_10)] |
| Total female population (%) | 137,477 Inhabitants (51%) | 252,149 Inhabitants (51%) |
| Total female population aged 9-13 years (% of total female population) | 21 565 Inhabitants (16%) | 39 553 Inhabitants (16%) |
| Number and type of public health facilities | RefHC = 1  ComHC = 17 Operational and 3 non-operational areas [[11](#_ENREF_11)] | RefHC = 1  ComHC = 10 [[12](#_ENREF_12)] |
| Number and type of health workers in all district public health facilities | Doctors = 15  Sanitation engineer = 1  Medical assistants = 4  Senior health technicians = 15  Midwives = 6  Obstetric nurses = 6  Senior laboratory technician = 1 Lab technicians = 3  Health technicians = 35  Traditional birth attendants (matrons) = 35  Nursing assistants = 44 [[11](#_ENREF_11)] | Doctors = 41  Medical assistants = 30  Senior health technicians = 75  Midwives = 19  Obstetric nurses = 19  Health technicians = 44  Traditional birth attendants (matrons) = 24  Nursing assistants = 17  Health assistants = 41  Administrators = 4  Support staff = 35  Storage facility managers = 20 [[12](#_ENREF_12)] |
| Number and type of private health facilities | Private clinics = 1  Primary care practices = 3  Religious facility = 1  Inter-entity medical center (CMIE) = 1 [[11](#_ENREF_11)] | Medical clinics = 12  Surgical clinics = 3  Primary care practices = 9  Midwife consulting practice = 4  Radiology practice = 1  Dental practice = 1  Medical and care consultation practice = 17  Multi-clinics = 3 [[12](#_ENREF_12)] |

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1: Fana** | **District 2: Commune V in Bamako District** |
| Number and type of health workers on staff in private health facilities in the district | Doctors = 6  Senior health technicians = 3  Health technicians = 7  Obstetric nurses = 5  Nursing assistants = 6  Midwives = 2 [[11](#_ENREF_11)] | Doctors = 52  Medical assistant = 1  Senior health technicians = 13  Health technicians = 24  Midwives = 20  Obstetric nurses = 15  Traditional birth attendants (matrons) = 20  Storage facility managers = 8  Support staff = 35 [[12](#_ENREF_12)] |
| Number and type of public and private primary and secondary schools 1st cycle and 2nd cycle | Public schools 1stcycle = 99  Private schools 1st cycle = 9  Community schools 1st cycle = 43  Madrasa 1st cycle = 70  Public schools 2nd cycle = 27  Private schools 2nd cycle = 2  Community schools 2nd cycle = 1  Madrasa 2nd cycle = 10 [[13](#_ENREF_13)] | Public schools 1stcycle = 48  Private schools 1st cycle = 151  Community schools 1st cycle = 19  Madrasa 1st cycle = 46  Public schools 2nd cycle = 33  Private schools 2nd cycle = 107  Community schools 2nd cycle = 12  Madrasa 2nd cycle = 34 [[13](#_ENREF_13)] |
| Number of teachers in public and private primary and secondary schools: 1st cycle and 2nd cycle | Public 1stcycle = 415  Private 1st cycle = 39  Community 1st cycle = 134  Madrasa 1st cycle = 226  Public 2nd cycle = 194  Private 2nd cycle = 12  Community 2nd cycle = 2  Madrasa 2nd cycle = 34 [[13](#_ENREF_13)] | Public 1stcycle = 360  Private 1st cycle = 1,141  Community 1st cycle = 140  Madrasa 1st cycle = 348  Public 2nd cycle = 418  Private 2nd cycle = 689  Community 2nd cycle = 65  Madrasa 2nd cycle = 207 [[13](#_ENREF_13)] |
| Estimates of the number and percent of girls attending school for each of the following ages:  9-year-old girls  10-year-old girls  11-year-old girls  12-year-old girls  13-year-old girls | Total girls  = 21 565  Total girls attending school  = 6,633 (31%)  1,704 (25.69%)  1,654 (24.94%)  1,335 (20.13%)  1,093 (16.48%)  848 (12.78%) [[14](#_ENREF_14)] | Total girls = 39 553  Total girls attending school = 20,678 (52%)  3,738 (18.08%)  3,809 (18.42%)  4,042 (19.55%)  4,299 (20.79%)  4,790 (23.16%) [[15](#_ENREF_15)] |
| Estimates of the number and percent of girls not attending school for each of the following ages:  9-year-old girls  10-year old girls  11-year-old girls  12-year-old girls  13-year-old girls | Total girls not attending school  = 14 932 (69%)  3,148 (21.08%)  3,084 (20.65%)  3,013 (20.18%)  2,914 (19.51%)  2,774 (18.57%) [[10](#_ENREF_10)] | Total girls not attending school  = 18,875 (48%)  3,979 (21.08%)  3,898 (20.65%)  3,809 (20,18%)  3,683 (19.51%)  3,506 (18.57%) [[10](#_ENREF_10)] |

**Q6.** Please give a brief description of why this district (or districts) was (were) selected to participate in the HPV Demonstration Program.

To implement the HPV Demonstration Program, Mali opted for an application in two health districts:

**The Fana Health District was chosen for the following reasons**:

* + test district for the introduction of the MenAfriVacTM  vaccine in 2010;
  + medium-sized (269,563 inhabitants)[[10](#_ENREF_10)];
  + rural district, located 150 km from Bamako;
  + active participation by local authorities, with a strong capacity to mobilize community organizers and community leaders;
  + overall enrollment rate 49%;

In this district, the target will be covered using inclusive strategies that involve all civil society stakeholders. The demonstration program's success in the Fana district will guarantee success for the introduction of the vaccine in a rural area and at the national level.

**The Commune V Health District in Bamako District was chosen for the following reasons**:

* + urban area,
  + existence of a health facility that has good technical equipment,
  + the Commune V health district provides large amounts of data to Mali's national cancer register,
  + overall enrollment rate of 77% [[13](#_ENREF_13)].

In this municipality, the target will be met through the school environment with teacher support and the support of participants within civil society including neighborhood chiefs, traditional chiefs, religious leaders and opinion makers, traditional healers, local and administrative authorities. In the same vein, health stakeholders and local NGOs will be involved in the success of the vaccine demonstration program.

These two districts are fairly representative of the country's socioeconomic and cultural situation.

**Q7.** Please describe the operations of the EPI program in the district(s) selected for the HPV Demonstration Program.

Table III: EPI operations in the selected districts.

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1: Fana** | **District 2: Commune V in Bamako District** |
| Number and type of administrative subunits (e.g. health facilities) used for routine vaccine delivery | 20 ComHC and 1 RefHC | 10 ComHC and 1 RefHC |
| Number and type of outreach sessions in a typical month used for routine vaccine delivery | 105 educational talks, 6 radio programs and 11 home visits | 408 educational talks |
| PENTA3\* coverage | 107% in 2012 | 101% in 2012 |
| Polio3 coverage | 107% in 2012 | 101% in 2012 |
| Measles first dose coverage | 91% in 2012 | 78% in 2012 |
| \*\*TT2+ (pregnant women) | 88% in 2012 | 82% in 2012 |

Source: 2012 Administrative EPI Data [[15](#_ENREF_15)] .

\* **PENTA3** = 3rd dose of diphtheria, tetanus, pertussis, viral Hepatitis B, Haemophilus influenzae type b vaccine.

\*\* **TT2+ =** proportion of pregnant women having received the 2nd dose of TT2 and higher.

The 2 districts use collection tools, analysis and transmission of the local health information system (immunization records, tally sheets, daily immunization reports, monthly immunization reports, quarterly reports, health development software for Mali (DESAM). These documents are used throughout the Mali

**Q8.** Please summarize the performance of the district EPI program as reported in any recent evaluation, for example identifying resources available, management, successes, and challenges.

Mali organized a review of its Expanded Program on Immunization (EPI) from May to July 2006, after the 1998-1999 review. This review highlighted the following points:

Satisfactory immunization coverage rates for children aged 12 to 23 months (77% for measles and 67% of children correctly immunized);

* Around 99% of mothers of children between the age of 12 to 23 months have a positive attitude toward immunization;
* A high percentage of immunization workers have received formal training on EPI (80.9%);
* Inclusion in the State budget of a line item for the purchase of routine vaccines;
* Weak capacity for mobilizing community health association resources to ensure responsibility for the operation of the cold chain and of mobile equipment
* Inadequate storage volume in cold rooms at the central level during mass campaigns and when a pentavalent was introduced and also from a GIVS perspective;

The immunization coverage study conducted in 2010 enabled a 75% immunization coverage for Penta 3 in children aged 12 to 23 months.

This evaluation highlighted incomplete vaccinations and the rate of children who had never received antigens (6%). The main reasons given for this were: customs, lack of knowledge about need for immunization, and the absence of an individual to administer vaccinations.

Administrative immunization coverages in 2010 for measles (89%) and Penta 3 (92%) were lower than the coverages that were targeted by the EPI in 2009 in Mali (97% for measles and 98% for Penta3).

The performance of the EPI in the two selected districts is summarized in the Table below.

Table IV: Immunization coverage trends in the Fana health district

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicators** | **2008** | **2009** | **2010** | **2011** | **2012** |
| Penta 3 | 109 | 79 | 111 | 81 | 107 |
| VAR | 107 | 75 | 73 | 83 | 91 |
| TTV2 and higher | 94 | 52 | 44 | 56 | 88 |
| Penta 1- Penta 3 dropout rate | 22 | 22 | 18 | 20 | 1 |

Table V: Trends in immunization coverage in the Commune V health district

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicators** | **2008** | **2009** | **2010** | **2011** | **2012** |
| Penta 3 | 153 | 101 | 76 | 102 | 101 |
| VAR | 105 | 86 | 85 | 81 | 78 |
| TTV2 and higher | 68 | 69 | 67 | 69 | 82 |
| Penta 1- Penta 3 dropout rate | 11 | 9 | 11 | 10 | 7 |

**Q9a.** Please describe any current or past linkages the district EPI program has had with the primary and/or secondary schools in the district, e.g., going to schools for health education, delivery of vaccinations, outreaches, etc.

During the MNT, meningitis (MenAfriVacTM), NID Polio, measles, yellow fever and chemio-prophylaxis for neglected tropical diseases immunization campaigns, the Nutrition Activities Intensification Week, school officials, teachers and community leader resources have been used with success.

In addition, there is a national school medical program and the promotion of good hygiene practices in a school environment (hand washing, screening). These programs are carried out in close cooperation with the Ministry of Education and Literacy and the Promotion of National Languages.

Activities carried out in the 2 health districts' schools are the following:

In the Fana health district

* + student medical visits
  + free daily consultations together with PEGs to continue
  + immunization in the schools specifically during campaigns (immunization against maternal and neonatal tetanus, immunization against polio, meningitis, etc.)
  + the building of latrines in the schools through the support of local NGOs

In the Commune V health district

* + quarterly medical visits
  + immunization in the schools during campaigns (immunization against maternal and neonatal tetanus, immunization against measles, polio, etc.)
  + Mass treatment for neglected tropical diseases
  + Behavioral Change Communication to encourage Family Planning.

**Q9b.** Please indicate if gender aspects relating to introduction of HPV vaccine are addressed in the demonstration program.

Considering the disease burden on the female portion of the population, priority will be given to immunizing 10-year-old girls for this demonstration. However, to take the gender question into account, communication and social mobilization activities will be conducted to target other girls, boys and the general population in the first year. When the results of the assessment on the feasibility of integrating health activities for adolescents are known, specific activities will be implemented for all adolescents, in schools as well as the community.

**Q9c.** Please describe any recent evidence of socio-economic and/or gender barriers to the immunization program through studies or surveys?

According to the Health IV demographic study carried out in 2006, the number of children who receive no immunizations decreases with the mother's level of education: it varies from 14% among children whose mothers have had no education to 3% among those whose mothers have had secondary schooling or higher. If the results as related to household economic status do not show significant gaps in the first four quintiles, it can be noted, however, that immunization coverage is significantly better in the wealthiest quintile where only 7% of children have received no immunizations, as opposed to around two times more than this in the other quintiles.

The 2010 immunization coverage study showed that customs, travel by mothers and the absence of an individual to administer vaccinations are the main obstacles to immunization.

* 1. Objective 1: HPV vaccine delivery strategy

**Q10.** Please describe the primary and secondary HPV vaccine delivery strategies selected (school-based, facility-based, outreach, mixed, other, etc.) and the rationale for selection.

**Note**: If the application proposes to use school as a venue for HPV vaccine delivery the minimal proportion of girls of the target vaccination cohort or target grade that is enrolled in school must be 75% nationwide (not only in the selected district).

Mali has opted for a mixed approach (school and community) for this demonstration.

Girls attending primary or secondary school will receive the vaccine at their schools with the support of the teaching staff; girls who are not attending school will be reached using fixed and outreach strategies through peer educators, community liaisons and leaders for the census and the mobilization of the girls.

**Q11.** If schools are being used as a venue for HPV vaccine delivery, please state the percentage of girls in the target age group which are attending school nationwide and in the district(s).

* Commune V in Bamako District: 77%.
* Fana health district: 49%.

**Q12.** Please identify a single year of age (or single grade in school) target vaccination cohort within the target population of 9-13 year-old girls and provide information in the table below. Please clarify the rationale for the choice of the target population.

10-year-old girls will be targeted for the demonstration This decision takes into consideration the early age at which marriage occurs and at what age first sexual relations occur.

In a school environment, 10-year-old girls in all grades in primary or secondary education will be the main target.

Girls who are not attending school but who are in this same age group will be the main target within the community.

Table VI: Age selection for immunization cohort targeted at girls aged 9 to 13.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Target age or grade** | **No. of girls targeted Year 1-Fana** | | **N. of girls targeted Year 1-Commune V** | | **Data source** |
| [10 yrs] | [1,654] | In school | [3,809] | In school | [- CAP Fana Report on new school year (Académie Kati, Mali). 2012.  - CAP report on new school year for Torokorobougou and Kalaban Coura (*Académie Rive Droite*, Bamako, Mali). 2012.] |
| [10 yrs] | [3,084] | Out of school | [3,898] | Out of school | General Census of the Population and Habitat, Mali 2009] |
| **T** | [4 738] |  | [7,707] |  |  |

In a school environment, all 10-year-old girls in primary and secondary establishments will be the main target, knowing that it is during the school year that the maximum amount of girls in this age group (9 to 13 years old) can be found.

Girls who are not attending school and in this same age group will be the main target within the community.

**Q13.** If the target population is a single grade in school, describe the percentage of girls in the target grade between the ages of 9 and 13 years and the data source.

Table VII: Distribution by age of girls attending school 9 to 13 years old compared to all girls

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Ages** | **Girls attending school** | **T** |  | **Ratio** |
| 9 yrs | 5,442 | 12,569 |  | 43.30% |
| 10 yrs | 5,463 | 12,445 |  | 43.90% |
| 11 yrs | 5,377 | 12,199 |  | 44.08% |
| 12 yrs | 5,392 | 11,989 |  | 44.97% |
| 13 yrs | 5,638 | 11,918 |  | 47.31% |
| **TOTAL** | **27,312** | **61,120** |  | **44.69%** |

|  |  |
| --- | --- |
|  |  |
| **Figure 4**: Distribution by age of girls attending school 9 to 13 years old compared to all girls, in Fana. | **Figure 5**: Distribution by age of girls attending school 9 to 13 years old compared to all girls, in Commune V. |

**Note**: If the strategy selects eligible girls based on their grade in school, then at least 80% of the girls in the grade should be between 9 and 13 years of age (the WHO-recommended age group for HPV vaccine).

**Q14.** Please describe how eligible girls not attending school will be identified and the mechanism for providing them an opportunity to receive HPV vaccine.

Within the community, the community liaisons and community health workers will take a census of all of the 10-year-old girls in each village and neighborhood, as a joint project with the mayors and administrative and traditional authorities.

Administrative support available from the mayor's offices and health facilities and administrative census documents will be used to estimate girls' age.

An inclusive and inclusive search will be undertaken to make girls not attending school and their parents aware of the program. Immunization workers will go to villages and neighborhoods on the dates scheduled for immunization and, with the assistance of the community health workers, community liaisons and village chiefs, they will vaccinate all girls previously identified in the census. Village chiefs, community liaisons and health workers will be notified of the dates and times that the immunization workers will be available as to facilitate the mobilization of the girls. The girls' census information sheets will be used to identify girls during the immunization sessions and will allow for selecting the girls. At the end of each immunization day, the list of girls absent is communicated to the liaisons, peer educators, health workers and village chiefs so that they can be located and brought to the immunization sites.

Due to the importance of communication in Mali society, the support of women's associations, civil society, religious leaders and opinion leaders will be sought.

CNIECS and the National Department for the Promotion of Women and Children will map out the women's and youth associations and groups within the two districts to help select the most influential and dominant groups and associations within the community. The groups and associations identified will participate in activities to raise awareness among the population. For the three-dose sequence, they will contribute to identifying and mobilizing girls who are not attending school for immunization as well as monitoring them.

At the same time as these associations and groups, other groups made up of the teaching staff will be linked with the *Centres d’Animation Pédagogique* (Centers for Educational Activities) to identify and mobilize girls attending school for immunization as well as monitoring them.

Community health workers, community liaisons and heads of household and traditional chiefs will be involved in the program's success. For the outreach strategy, girls will be immunized in health facilities at stationary centers in villages and neighborhoods.

**Q15.** Please describe the mechanism for reaching all the target girls with three doses who were missed on the main vaccination days, specifying plans for reaching hard-to-reach or marginalized girls.

To administer vaccine doses to all girls who were absent during the main immunization days, follow-up sessions will be organized using school, village and neighborhood census records.

Once identified, each girl will receive her first dose and an immunization card. Two copies of this card will exist and it will contain the information necessary for identification. One copy of the card will be given to the girl immunized and the other card will be kept by school or health authorities

The immunization record will be updated to take into account administrative data (first and family names, date of birth, address of usual place of residence and telephone contact numbers, etc.). A record of girls absent during the main immunization sessions is to be filled out at the end of each immunization session. This record will be used by the community workers and liaisons to locate absent girls and to direct them to the follow-up immunization sessions.

Each district covered by the program will have computers to use. The computers will be networked and the database will be updated at regular intervals and accessible by all immunization workers.

In parallel, an SMS alert system will be initiated to send immunization date reminders and notifications of missed appointments.

During this demonstration program, the health team will work in close cooperation with school authorities to reduce absences; information will be shared the day before the activity to maximize mobilization. Active search support and a database will be put in place. The teaching staff and community health workers will be communicating closely at each stage. Active searching will take place for those who are no longer present in the system.

**Q16.** Please summarize 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).

Since 2001, Mali has gained vast experience in introducing under-used and new vaccines as part of the EPI. The vaccines that have been introduced are yellow fever (2001), Hepatitis B (2002), Hib (2005), MenAfriVacTM (2010), Pneumo (2011), Rotavirus (2013).

* The yellow fever vaccine was introduced in Mali in 2001 using a pilot phase that was supported by the Japanese development agency.
* The Hepatitis B vaccine was introduced as part of the routine EPI in Mali in September 2002 and was GAVI funded. An introduction plan is drafted and validated by the ICC.
* The Hib vaccine was introduced in July 2005 through GAVI funding, in 3 stages. The 1st stage addressed the introduction of the vaccine in July 2005, in the city of Bamako. The 2nd stage addressed the introduction of the vaccine in 2006, into regional capitals. The 3rd stage was completed in 2007 with the expansion of the vaccine to the entire country.
* The introduction of the MenAfriVacTM vaccine in Mali took place in three consecutive stages in preventive campaigns. Mali is one of the first three countries to have introduced the MenAfriVacTM meningitis-A conjugate vaccine. The 1st phase of the introduction of the vaccine took place in the districts of Dioïla and Fana in 2010, the 2nd phase in the three regions of Koulikoro, Segou and Bamako in 2010 and the 3rd phase nationwide in 2011.
* The pneumococcal (PVC13) vaccine was introduced in 2011 to the entire country, one time, funded by GAVI.
* A Rotavirus vaccine introduction is planned in 3 phases to start at the end of 2013 and is funded by GAVI. During the 1st phase, the vaccine will be introduced into Bamako at the end of 2013, the 2nd phase will address the regional capitals and the 3rd phase will be nationwide.

To introduce all these antigens into the routine EPI, significant efforts have been taken, including:

* Evaluation and strengthening of the cold chain,
* Revision and adaptation of modules, support and management tools,
* Strengthening personnel capacity,
* Strengthening the system for managing biomedical waste,
* Evaluation of the morbidity and mortality burden for each disease to be prevented by immunization.
* Strengthening the cold chain and vehicle logistics:

To introduce these vaccines, a specific focus was given to strengthening cold chain capacity, with, in particular, the acquisition of equipment and personnel training related to management and maintenance. Using information from these evaluations, a significant amount of equipment has been acquired, funded by partners (European Union, UNICEF, Japanese development agency) a from the State budget; this has significantly contributed to improving the system of vaccine supply and distribution in Mali. It is noteworthy that in July 2011, Mali conducted an EVM assessment, resulting from an improvement plan; it led to the development of a rehabilitation plan for the cold chain and logistics. This plan is currently being implemented through the installation of two new cold rooms of 30 m3 each, funded through the State budget as well as the installation of an continual modern temperature monitoring system in the central cold rooms and the purchase of around 250 solar refrigerators, funded by UNICEF.

To implement this phase of the demonstration, the quantities of HPV vaccine will be received and stored at the central level before routing them to the relevant districts. Carried out using the WHO EPI-Forecasting-Tool, the data analysis of the central facility's storage capacity shows that the capacity is sufficient to store the vaccines before they are distributed. There is no need to invest for an expansion at the central level.

Regional resupply of vaccines and supplies is ensured by the Immunization Section using two trucks acquired in 2000 and 2003 using UNICEF and European Union funding; these trucks are currently not in good operational order. At the regional level, three regions (Kayes, Sikasso and Mopti) have trucks with which to transport vaccines and supplies. In the health districts, resupply is ensured by designated pick-ups (vehicles) that are also used for the supervision of field activities.

For the supervision of activities, the central level has a single vehicle that is in good operational order. For this reason, it is important to acquire 4 (four) 4X4 vehicles (2 Land Cruisers and 2 double cabin pick-ups).at the central level.

* Strengthening waste management that is the result of immunization.

With regard to strengthening vaccine waste management, Mali adopted an injection safety policy in 2002. Since then, particular focus has been placed on injection safety and on the safe disposal of biomedical sharps immunization waste. When multiple immunization campaigns are being organized (measles, yellow fever, meningitis and MNT), a biomedical waste management plan is available at all levels. Therefore, all health districts have high-performing incinerators (De Montfort, Dragon and AJA). This helpful knowledge acquired during various campaigns will be used and will allow for better management of the waste generated during this phase of the demonstration. In the Fana district, there are more than operational 3 (three) incinerators (Fana, Marakakoungo, Béléko) which will be used to dispose of the waste collected. In the Commune V district, there is an operational incinerator at the RefHC site that will be used to dispose of all waste collected.

* Adverse Effects Following Immunization.

The system of surveillance for Adverse Effects Following Immunization (AEFI) implemented in the districts during various immunization campaigns and during the routine activities will be reinvigorated and strengthened to respond to requirements. In each district, there is a pharma-monitoring committee with proven experience. Notification of AEFI cases will be communicated via the monthly immunization reports. A strong emphasis will be placed on training health workers on how to report and manage possible AEFI cases.

**Q17.** 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 ice packs (e.g., supply shortages or excesses), and plan for HPV vaccine storage and distribution during the HPV Demonstration Program.

For the two health districts (Fana, Commune V) concerned for this phase of the demonstration, analysis shows that the cold chain lacks positive storage capacity. This deficit is in the magnitude of 162 liters for the Fana district and 231 liters for the Commune V district (see Table VI). This gap will be reduced by the acquisition of four (4) Vestfrost VLS 400 PQS E003/021 refrigerators, a net storage capacity of 216 liters, two (2) of which are for the Fana district and two (2) the Commune V district. With regard to negative freezing capacity for the ice packs, the analysis shows that capacity is sufficient within the two health districts.

Table VIII: Evaluation of positive storage capacity and the cost of investment in the Fana and Commune V health districts

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Headings** | **Formulas** | **Fana** | **Commune V** |
| **A** | Total annual volume of vaccines in positive storage | *Number obtained by multiplying the total number of vaccine doses by the volume per dose* | 2,168 L | 3,979 L |
| **B** | Net existing total positive capacity in the cold chain | *#* | 110 L | 267 L |
| **C** | Estimated minimum number of shipments per year required for the actual cold chain capacity | *A/B* | 19.80 | 14.93 |
| **D** | Number of annual shipments | *Based on national vaccine shipment plan* | 12 | 12 |
| **E** | Gap (if any) | *[A\*(1/D+Stock\_reserve/12) – B]* | **162 L** | **231 L** |
| **F** | Estimated expansion cost | *USD* | $1,114 | $1,114 |

*L: liter.*

Table IX: Cold chain situation in Fana and Commune V Districts.

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1: Fana** | **District 2: Commune V in Bamako District** |
| Number and type of cold chain devices | ComHC Refrigerators = 20  RefHC Freezers = 3  ComHC Freezers = 3 | ComHC Refrigerators = 13  Freezer = 1  Combined refrigerator/freezer = 2  The brands are: Electrolux TCW2000; Electrolux TCW 1990;TFW 800; TCW 1151 |
| Operational status of cold chain device | Mixed devices (oil/electricity)  Operational refrigerators = 18  Operational freezers = 3 | Operational refrigerators =12  Operational combined refrigerators/freezers = 2  Operational freezers = 1 |
| Storage capacity (any excess) | Refrigerators = 110 liters  Freezers  = 480 liters | Refrigerators = 267 liters  Freezers  = 187 liters |
| Distribution mechanism | Considering the proximity of Fana to Bamako, the district will be directly supplied from the central storage facility and resupply will be conducted by the central level | Considering the proximity of Commune V to the central level, the district will be directly supplied from the central storage facility and resupply will be conducted by the central level |
| Number and status of vaccine carriers | Vaccine carriers = 80 in good condition  Insulated boxes = 20 | Vaccine carriers = 48 in good condition  Insulated boxes = 10 |
| Number and status of ice packs (any shortages or excess) | Need = One (1) 94-liter refrigerator in 2014 (VLS 400, PQS E003/021) and One (1) 271-liter freezer in 2014. | Need = Two (2) 216-liter refrigerators (VLS 400, PQS E003/021), one (1) of which is needed in 2014 and one (1) in 2015 |

Note: there is not a cold room in these districts but there are freezers and refrigerators for the cold chain.

**Q18.** Additional district cold chain information if necessary:

For this phase of the demonstration, distribution of immunizations and HPV inputs will be taken care of directly from the central level to the Fana Commune V district storage facilities. The coolers and insulated boxes will be used to for resupplying these districts. In that the district of Fana is located about 150 km from Bamako, the central level truck will be used to transport all vaccines and the inputs at Fana. In that the Commune V health district is located only about 10 km from the central level, the pick-ups will be used for resupplying. Health areas will be supplied from storage facilities in the health districts. Supervision vehicles available to these districts will be used to transport the vaccines using coolers and insulated boxes.

To immunize the targeted individuals, the three strategies (fixed, outreach and mobile) will be used. Resupplying vaccines to teams out in the field will be done using vaccine carriers. Data analysis shows that two health districts (Fana and Commune V) have sufficient quantities of coolers to distribute vaccines to health areas (see table VII).

* 1. Objective 1: HPV vaccine delivery training and community sensitization & mobilization plans

**Q19.** Please describe initial plans for the training of health workers and others who will be involved in the HPV Demonstration Program.

From past experience in EPI management and the introduction of new vaccines in Mali, the training workshops will be organized for the stakeholders involved at various levels.

With the support of partners, the modules developed to introduce new vaccines that already exist will be adapted and used for different trainings.

* At the national level: the stakeholders will be trained in the planning, supervision and monitoring of program activities,
* Decision makers will be briefed on the advantages and changes to activities in the vaccine demonstration program,
* At the national level from a technical perspective: supervisory, communication, technical package monitoring, and vaccine administration teams will be trained.
* At the district level, technical immunization teams will be created and trained in the use of computerized support and vaccine administration,
* Periodic updated trainings will be organized for first-level stakeholders.
* To manage feedback, inclusive training sessions will be organized.

**Q20.** Please describe initial communication plans for sensitizing and mobilizing communities for the HPV Demonstration Program.

**1. Communication Objective**

Mobilize populations of the Fana health district and Commune V of the Bamako District around the demonstration program for the immunization of 10-year-old girls against cervical cancer by 2016.

**Specific objectives:**

* Motivate 95% of administrative, political, religious and community leaders to support the immunization activities against cervical cancer by 2016;
* Motivate 90 % of the parents of 10-year-old girls and the community to support the immunization activities against cervical cancer by 2016;
* Establish partnerships to plan the implementation, the monitoring of immunization against cervical cancer by the end of 2014;
* Motivate 95% of parents to accept and fully immunize their 10-year-old girls against cervical cancer by the end of 2016.

**2. Strategies:**

Advocacy, social mobilization, communication for social change and behavior changes will constitute the strategic pillars of promotional actions for the demonstration phase for HPV immunization in Commune V in Bamako and in the Fana health district.

**2.1. Advocacy:**

Lobbying will be directed to the Ministries, Partners and leaders of this activity due to the problematic issues linked to promoting this vaccine. An advocacy workshop will be organized at the national level and aimed at those in charge of the relevant ministerial departments (Ministry of Education, Ministry of the Family and the Promotion of Women and Children, Ministry of Finance, Ministry of Social Development and Solidarity for Elderly Individuals and the Mayor's Office of the District of Bamako).

A launch will be organized in the Fana health district, chaired by the highest authorities in the country, to make the event a high-profile one.

**2.2. Social mobilization**

To further mobilize communities, information days will be organized in the two health districts (Fana and Commune V) so that other elements of society such as school directors, religious leaders, community leaders, radio hosts and civil society participate.

Mali does not have a document adapted for communications about cervical cancer; therefore, a module will be drafted for the program, intended for teachers, community liaisons, radio hosts, traditional communicators, peer educators, associations and groups for women, religious groups, etc. This module will be adapted for each level, for all stakeholders, to better prepare them for the task of sharing information and raising awareness.

Communication documents will be developed and copied (100 copies of a brochure, 100 copies of a technical note intended for teachers and associations, banners, t-shirts, caps, for the launch in Fana). Two-way radio messages (announcements, microprogramming, programs) will be drafted and tested with participation from the community.

To disseminate these messages, 10 radio stations will be used for the two locales (5 radio stations in Fana and 5 in Commune V) and the time slots will be chosen by the communities themselves.

A CAP survey will be conducted in Commune V in the Bamako district to have a basis for the intervention strategy in an urban area. A similar study was conducted in Fana in 2010 for the MenAfriVacTM vaccine. The data from this study helped to identify strategies and potential participants in rural areas.

**2.3. Communication for Social Change and Behavioral Change**:

At least 60 community organizers (2 organizers per health area) and 200 peer educators (exactly 2 girls per school) will be used at the household- and school-levels to raise awareness in areas near to Fana and Commune V in the Bamako District, to share the message in school and with families.

Educational talks will be organized in the ComHC during immunization activities. This will allow for a wide range of information about the disease to be provided to mothers on the importance of immunizing 10-year-old girls and on early screening for cervical cancer.

In Mali, religious leaders are essential allies when promoting health activities. Women and youth networks will contribute to disseminating the message to their followers in houses of worship or through various meetings.

**Q21.** Briefly describe any initial thinking about potential barriers or risks to community acceptance and the process or communication plan that might be used to address this. Consider briefly describing any positive leverage points that might be beneficial for program implementation to promote acceptability.

* The weak involvement of community leaders: village chiefs, religious authorities, traditional healers, those responsible for women and youth groups;
* Lack of interpersonal communication;
* Inadequate participation by potential communication participants such as traditional communicators, teachers, community liaisons, etc.;
* Possible rumors about the immunization of girls;
* Fear of side effects;
* Seriousness of the disease (people have a tendency to think that it is a disease that can't be prevented or that is incurable);
* Lack of information among the population about the disease and the new vaccine
* Lack of information on screening for the disease;
* Insufficient exchange between mothers and health workers, leading to a lack of commitment to the new vaccine;
* Lack of participation by the community in planning, implementation and monitoring of social mobilization activities;
* Difficulties linked to discussions about sex in general and to discussions about female genitalia in particular;
* The low level of participation by Ministerial Departments (such as the Ministry of Family and the Promotion of Women and Children, Ministry of Education, Literacy and the Promotion of National Languages, Ministry of Finance, Ministry of Social Development, Solidarity and the Elderly).

To facilitate acceptance of the program and its implementation, positive mechanisms will be developed:

* Lobbying will be directed to the Ministries, Partners and leaders of this activity due to the problematic issues linked to promoting this vaccine. An advocacy workshop will be organized at the national level and aimed at those in charge of the relevant ministerial departments (Ministry of Education, Ministry of the Family and the Promotion of Women and Children, Ministry of Finance, Ministry of Social Development and Solidarity for Elderly Individuals and the Mayor's Office of the District of Bamako).
* Information days will be organized in the two districts (Fana and Commune V) to encourage the participation of other elements of society such as school directors, religious leaders, community leaders, radio hosts and civil society.
* The dissemination of messages on 10 radios stations is planned for the two locales (5 radio stations in Fana and 5 in Commune V) and the time slots will be chosen by the communities themselves.

* 1. Objective 1: HPV vaccine delivery evaluation plan

**Q22.** Indicate the agency/person who will lead the evaluation required for the “Learn by Doing” objective.

To evaluate this phase of the demonstration, a multidisciplinary team will be put in place under the aegis of the Ministry of Health. The health department will be supported by various partners (WHO, UNICEF, USAID, CVD-CNAM, etc.). This team will be made up of independent consultants trained for this specific situation. The aspects of the evaluation are, among others:

* Immunization coverage,
* Logistics (the supply chain, the cold chain, vaccine management, waste management),
* Social mobilization to encourage community support,
* Evaluation of the feasibility of integration with other health activities relate to adolescent reproductive health,
* Evaluation of all of the immunization demonstration program's stages in Mali,
* AEFI surveillance

WHO will lead the evaluation team required for the “Learn by Doing” objective.

* 1. Objective 2: Assessment of adolescent health interventions

**Q23.** Please summarize the anticipated activities for the assessment of adolescent health interventions, such as planning milestones, stakeholder meetings, methodology for the assessment, process for identifying a lead for this activity, and the process to involve the TAG in this work.

There is a national strategic plan for the health of youth and adolescents that will be implemented as two components:

* Information, education of youth and adolescents about health problems, raising parents' awareness about reproductive health.
* The implementation of policies and service standards for youth and adolescents in youth centers.

The activities that will be carried out to evaluate health interventions targeted at adolescents are the following:

* Creation of an evaluation team that will be essentially made up of the members of the technical advisory group
* Development of an protocol that specifies relevant information, methods, data collection sources, analysis methods, the timeline and budget
* Validation of the protocol with the participating parties and mobilization of the necessary resources
* Implementation of an actual survey, analysis and data interpretation
* Draft report
* Present report to the ICC for it to approve the main decisions, after a meeting of the members of the technical advisory group
  1. Objective 3: Development or revision of cancer control or cervical cancer prevention and control strategy

**Q24.** Please summarize 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.

In Mail, there is a national strategic plan for the prevention of cervical cancer for the 2011-2015 period; this plan's priority activities are focused on the primary prevention by raising awareness, screening for precancerous lesions and treating precancerous lesions and confirmed cases of cancer.

This plan will be revised to take into account the prevention via immunization using the following steps:

* Analyze the situation (documentary review, data collection)
* Organize workshop to validate the analysis of the situation by the steering committee
* Organize a workshop to revise the plan
* Organize a meeting of the steering committee to validate the revised plan
* Organize a meeting of the ICC, ton include TAG, to validate the plan
* Organize a round table to prepare a revised plan to submit to Technical and Financial Partners for funding
  1. Technical advisory group

**Q25.** 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 Demonstration Program and list the representatives (at least positions, and ideally names of individuals) and their agencies.

* Countries are encouraged to use their ICC or a subset of the ICC as the multi-disciplinary TAG.
* The TAG must at least have representatives from the national EPI program, cancer control, education, and the ICC (if separate from the ICC), and adolescent and/or school health (if they are represented within the Ministry of Health).

Enter family name in capital letters.

Table X: Composition of the Technical Advisory Group

|  |  |  |  |
| --- | --- | --- | --- |
| **Structures** | **Name** | **First name(s)** | **Area of Representation** |
| Charles Mérieux Center for infectiology (CICM) | Diallo | Souleymane | Laboratory |
| Pathologic Cytology Anatomy/CHU Point ''G'' | Traore | Cheick Bougadari | Cervical Cancer Prevention |
| Pathologic Cytology Anatomy Department/HUC Point ''G'' | Kamate | Bakarou | Cervical Cancer Prevention |
| Gynecology Obstetrics Department/HUC Gabriel Toure | Teguete | Ibrahim | Cervical Cancer Prevention |
| Gynecology Obstetrics Department/HUC Point ''G'' | Sima | Mamadou | Cervical Cancer Prevention |
| Medical Hematology and Oncology Department/HUC Point ''G'' | Ly | Madani | Cervical Cancer Prevention |
| Medical and Laboratory Pharmacy Department | Kaloga | Assitan | Pharmacy |
| Gynecology Obstetrics/Sikasso Hospital | Sylla | Mala | Cervical Cancer Prevention |
| Gynecology Obstetrics/Mali Hospital | Toure | Moustaphe | Cervical Cancer Prevention |
| National Health Laboratory | Koumare | Bénoit | Laboratory |
| Pediatric Oncology Department/HUC Gabriel TOURE | Togo | Boubacar | Cervical Cancer Prevention |
| **CVD-CNAM** | Sow | Samba | Immunization and Research |
| Kodio | Mamoudou | Immunization and Research |
| Dembele | Rokiatou (Diakite) | Immunization and Research |
| Niare | Fanta (Dembele) | Immunization and Research |
| **CNIECS** | Haidara | Souleymane | Communication |
| Traore | Souleymane | Communication |
| **IS** | Maiga | Aguissa Mahamane | Immunization |
| Kamissoko | Mady | Immunization |
| Konate | Famoussa | Immunization |
| Diaby | Bani | Immunization |
| Naco | Alima (Diallo) | Immunization |
| **NDH** | Kone | Nouhoum | Coordination |
| (Diakite) | Saran (Bore) | Reproductive health |
| (Dembele) | Marguerite Coulibaly | Adolescent Health |
| Diarra | Nazoum JP | Non-communicable diseases |
| Maiga | Oumou Soumana (Diakite) | Coordination |
| Dicko | Alassane Balobo | Disease control |
| Fofana | Soula (Goita) | Data management |
| Keita | Gaoussou | Waste Management |
| **DFM/Health** | Diarra | Gaoussou | Finances |
| **WHO** | Yalcouye | Idrissa | Immunization |
| Tounkara | Baba | Immunization |
| **UNICEF** | Ameh | George | Immunization |
| **USAID** | Bah | Mariam Ciré | Immunization |
| **Ministry of Finance** | Sidibe | Mahamadou | Finances |
| National Department of Primary and Secondary Education | Dicko | Rakiata | Education |
| National Department of the Family, Promotion of Women and Children | Djitteye | Fatoumata (Traore) | Communication and Health for adolescents |
| National Department of Social Development | Hama | Abdoulaye | Communication and Social mobilization |

1Area of representation can be cancer control, noncommunicable disease, immunization, adolescent health, school health, reproductive health, maternal or women’s health, cervical cancer prevention, nursing association, physicians, health communications, midwives, civil society group, education, etc.

**Q26.** If known, please indicate who will act as the chair of the technical advisory group.

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name/Title** | **Agency/Organization** | **Area of Representation** |
| Chair of Technical Advisory Group | Prof. Adama Diawara | Ministry of Health (Secretary General) | Health |

* 1. Project manager/coordinator

**Q27.** 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 Demonstration Program, taking note that a technical officer/lead/manager from EPI might be most suitable as a part of their current role and responsibilities.

Enter family name in capital letters.

Table XI: List of individuals in charge of daily program coordination for the HPV vaccine demonstration.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Dr. Aguissa Mohamane Maiga | **Title** | [Head of Immunization Unit] |
| **Telephone no.** | [223 20 22 39 20] |
| **Fax no.** | [223 20 22 77 99] | **Agency** | [National Department of Health] |
| **Email** | [cni@afribonemali.net, amagaml@yahoo.fr] | **Address** | [N’Tomikorobougou – Bamako – BP: 51] |
|  |  |

The National Department of Health's immunization unit will be responsible for coordination.

1. Timeline

The HPV Demonstration Program will include immunization of the cohort of girls in two consecutive years (Figure I). Countries are required to begin vaccinating in the demonstration district within two years of the application.

Table XII: HPV Demonstration Program timeline

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | First round of vaccination | | | Evaluation of first round | | Second round of vaccination | | | | | | | | |
|  | | Assessment feasibility integrated delivery  Start cancer control strategy | | | | | | If feasible, test joint delivery of services  Finalization of cancer control strategy | | | | | | | |
|  | |  | | |  | |  |  | |  |  |  |  |  |  |
| Planning | | Year 1: demonstration program implementation | | | | | | Year 2 | | | | | | | |
|  |  | |  |  |  |  | | |  | |  | |  | |  |

**Q28.** Please modify as necessary and complete the timeline below for the main activities for HPV vaccination, assessment of adolescent health interventions, and development/revision of a national cervical cancer prevention and control strategy planned for the HPV Demonstration Program. Countries should ensure enough time is scheduled for planning activities prior to delivery of HPV1. For program tracking purposes, Year 1 starts with delivery of the first dose of vaccine. Applicants may want to complete this in MS Excel.

Table XIII: timeline of main HPV immunization activities.

| Activities | 213 | 2014 | | | | | | | | | | | | 2015 | | | | | | | | | | | | | 2016 | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Jan | Feb | Mar | April | May | June | July | Aug | Sep | Oct | Nov | Dec | | Jan | Feb | Mar | April | May | June | July | Aug | Sep | Oct | Nov | Dec | | Jan | Feb | Mar | April | May | June | July | Aug | Sep | Oct | Nov | Dec |
| Establish TAG | X |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Draft implementation plan | x |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Communicating information to key stakeholders |  | X | X | X | X | X | X | X | X | X | X | X | X | | X | X | X | X | X | X | X | X | X | X | X | X | | X | X | X | X | X | X | X | X | X | X | X | X |
| Establish implementing team | x |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Establish team to conduct assessment of ADH interventions | x |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Develop plan and methodology for assessment of ADH interventions |  |  |  |  |  |  |  |  |  |  | x | x | x | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Establish team to work on cervical cancer strategy | X |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Develop plan with key stakeholders for process of developing / revising cervical cancer strategy |  |  |  | X |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Adapt IEC materials &communication plan |  |  |  |  |  | x | x | x |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Review and revise immunization support |  |  |  |  |  | x | x | x |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Confirm availability of storage space in the district |  |  |  |  |  |  |  | x |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Receipt of vaccines |  |  |  |  |  |  |  |  |  | x |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Prepare training plan |  |  |  |  |  |  |  | x |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| District microplanning |  |  |  |  |  |  |  |  |  | x | x |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement training plan |  |  |  |  |  |  |  |  |  |  | x |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement communication strategy in district |  |  |  |  |  |  | X | x | x | x | x | x | x | | x | X | x | x | x | x | x | x | x | x | x | x | | x | x | x | x | x | x | x | x | x | x | x | x |
| Transport vaccine to district |  |  |  |  |  |  |  |  |  | x |  | x |  | |  |  | x |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Deliver dose 1 |  |  |  |  |  |  |  |  |  |  | X |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Follow-up sessions for dose 1 |  |  |  |  |  |  |  |  |  |  | x |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Deliver dose 2 |  |  |  |  |  |  |  |  |  |  |  |  | X | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Follow-up sessions for dose 2 |  |  |  |  |  |  |  |  |  |  |  |  | x | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Deliver dose 3 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | X |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Follow-up sessions for dose 3 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | x |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Conduct assessment of feasibility of ADH interventions |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  | x |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Produce draft outline for cervical cancer strategy |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | x | x |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Conduct assessment of demonstration (immunization coverage, logistics, process, costs, AEFI, etc.) |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  | x |  |  |  |  |  |  |  | |  |  |  | x |  |  |  |  |  |  |  |  |
| Collect cost data |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  | X |  |  |  |  |  | |  |  |  |  |  |  | X |  |  |  |  |  |
| Analyze evaluation data |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  | X |  |  |  |  |  | |  |  |  |  |  |  | X |  |  |  |  |  |
| Write preliminary report of evaluation |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | X |  |  |  |  | |  |  |  |  |  |  |  | X |  |  |  |  |
| Write preliminary report of feasibility assessment of ADH interventions |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | X |  |  |  |  | |  |  |  |  |  |  |  | X |  |  |  |  |
| Review results from year 1 and outline any program delivery changes for year 2, including whether to do joint delivery of HPV vaccine and an ADH intervention |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | X |  |  |  |  | |  |  |  |  |  |  |  | X |  |  |  |  |
| Submit financial report to GAVI (15 months after funds disbursed from GAVI) |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | X |  |  |  | |  |  |  |  |  |  |  |  | X |  |  |  |
| Submit progress report to GAVI |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | X |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Top up training or program material revisions for year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | X |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Microplanning for year 2 delivery |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | x |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| If joint delivery done in year 2, revise evaluation plan from year 1 for year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | x |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| If joint delivery done in year 2, revise immunization forms, as needed |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | x |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Transport vaccine supply to district for year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | x |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement communication strategy in district |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | x | x | | x | x | x | x | x | x |  |  |  |  |  |  |
| Prepare first draft of full cervical cancer strategy |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Deliver dose 1 in year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | x | |  |  |  |  |  |  |  |  |  |  |  |  |
| Follow-up sessions for dose 1 in year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | x | |  |  |  |  |  |  |  |  |  |  |  |  |
| Deliver dose 2 in year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  | x |  |  |  |  |  |  |  |  |  |  |
| Follow-up sessions for dose 2 in year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  | x |  |  |  |  |  |  |  |  |  |  |
| Deliver dose 3 in year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  | x |  |  |  |  |  |  |  |
| Follow-up sessions for dose 3 in year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  | x |  |  |  |  |  |  |  |
| Conduct final assessment of demonstration while considering joint delivery (immunization coverage, logistics, process, costs, AEFI, etc.) |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | x |  |  |
| If joint delivery done in year 2, conduct cost analysis |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | x |  |  |
| If joint delivery done in year 2, collect and analyze feasibility data |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | x |  |  |
| Prepare second draft of full cervical cancer strategy |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| Analyze coverage, feasibility and cost data, if joint delivery done in year 2 |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | x |  |  |
| Draft evaluation report of year 2 vaccinations |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | x |  |
| Final recommendations to TAG and MOH for national scale-up of HPV vaccine, including decision on joint delivery |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | x |  |
| Submit financial report to GAVI (12 months after last report) |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | X |
| Submit final progress report to GAVI |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | X |
| Submit last draft of cervical cancer strategy to MOH |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | X |
| Hold dissemination meeting to key stakeholders |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | X |

1. Budget

**Q29.** 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.

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

Table XIV: Project budget for the first and second years.

|  |  |  |  |
| --- | --- | --- | --- |
| **Cost Category** | **Source of funding** | **Estimated costs per annum in US$** | |
| **Year 1** | **Year 2** |
| TAG meetings | [GAVI]: | 2,120 | 0 |
| Program management and coordination | [Ministry of Health]\* | 4,624 | 0 |
| Cold chain equipment | [Ministry of Health] | 15,124 | 0 |
| Other capital equipment (describe) | [Ministry of Health] | 5,000 | 0 |
| Personnel operational costs in the field (campaign), including salary supplements and/or per diem | [GAVI] | 25,992 | 25,992 |
| Transportation | [GAVI] | 5,900 | 3,876 |
| Training | [GAVI] | 5,254 | 0 |
| Community sensitization and mobilization | [GAVI] | 5,000 | 0 |
| Waste disposal | [GAVI] | 0 | 0 |
| AEFI surveillance | [GAVI] | 2,429 | 0 |
| Monitoring and supportive supervision | [GAVI] | 8,567 | 0 |
| Monitoring and supportive supervision | [Ministry of Health] | 0 | 8,567 |
| Assessment of immunization coverage | [GAVI] | 23,190 | 0 |
| Assessment of feasibility of integrating ADH with HPV vaccines | [GAVI] | 18,284 | 0 |
| Drafting national cervical cancer prevention and control strategy | [GAVI] | 19,000 | 0 |
| Technical assistance from local experts | [GAVI] | 39,000 | 0 |
| ***Subtotal for which GAVI funds are being requested*** | **[GAVI]** | **154,736** | **29,868** |
| ***Subtotal from other funding sources*** | **[**Ministry of Health**]** | **24,748** | **8,567** |
| **TOTAL** |  | **179,484** | **38,435** |

\*Ministry of Health= Ministry and partners at the national level

1. Procurement of HPV vaccines and cash transfer

HPV vaccines must 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.

**Q30.** Please indicate how funds for operational costs requested in your budget in section 6 should be transferred by the GAVI Alliance (if applicable).

There is a purchasing agreement between WHO and the Ministry of Health of Mali for management of funds by WHO

1. Financial Management Arrangements Data Sheet

Q31.

Table XV: Financial Management Arrangements Data Sheet.

| **Information to be provided by the recipient organization/country** | | | | |
| --- | --- | --- | --- | --- |
| 1. Name and contact information of the recipient organization(s) | **Ministry of Health** | | | |
| 2. Experiences of the recipient organization with GAVI, World Bank, WHO, UNICEF, GFATM or other donors-financed operations (e.g. receipt of previous grants) | **Yes or No?**  YES  **If YES**, please indicate grant name, years and grant amount:  GAVI/EPI Expanded Program on Immunization ISS   * 24/06/2008: **87,504,811** FCFA * 10/07/2008:**446,434,019** FCFA * 24/06/2008: **92,293,760** FCFA   HSS  and provide the following:  **For completed Grants:**   * What are the main conclusions with regard to use of funds? * The creation of two specific accounts, authorized by two signatures: that of the Director of Finance and Equipment in the Ministry of Health, representing the Ministry of Health and the Central Accountant of the Treasury representing the Ministry of Finance at the BDM-SA [Bank in Mali]. These accounts are for receiving GAVI ISS and HSS funds; * The analysis of disbursement requests, in compliance with the PRODESS procedure manual; * Development of withdrawal form to accompany all requests for disbursement; * Systematic production of monthly reconciliation statements.   **For on-going grants:**   * Most recent financial management (FM) and procurement performance rating? * The DFM was congratulated for its excellent management of GAVI HSS in 2010 during the Auditor General team visit and the GAVI audit visit; in contrast, small issues have been noticed with the management of GAVI EPI. * Financial management (FM) and procurement implementation issues?   Cumbersome administration: The National Directorate of Health expresses its needs in compliance with the plan approved by GAVI. Its needs are then analyzed by the DFM which prepares the disbursement applications for ACCT. | | | |
| 3. Amount of the proposed GAVI HPV Demo grant (US Dollars) | US$: 217,919 of which US$ 34,115 for the State and its partners and US$ 183,804 for GAVI. | | | |
| ***4. Information about financial management (FM) arrangements for the GAVI HPV Demo Program:*** | | |  | |
| * Will the GAVI Demo Program resources be managed through the government standard expenditure procedures channel? | | No, the funds will be managed by WHO | | |
| * Does the organization have an FM or Operating Manual that describes the internal control system and FM operational procedures? | | Yes, there is a an agreement between WHO and the MOH | | |
| * What is the budgeting process? | | The Ministry of Health addresses requests to WHO which, in turn, mobilizes resources | | |
| * What accounting system is used or will be used for the GAVI HPV Demo Program? Is this system manual or computerized? | | A budget is developed for the demonstration and the activities are funded and carried out in compliance with the budget audit  The accounting system is computerized | | |
| * What is the staffing arrangement of the organization in accounting, auditing, and reporting? Does the implementing entity have a qualified accountant on its staff assigned to the GAVI HPV Demo Program? | | WHO | | |
| * What is the bank arrangement? Provide details of the bank account at the Central Bank or at a commercial bank proposed to receive GAVI HPV funds and the list of authorized signatories. Include titles. | | WHO | | |
| * In the implementation of the HPV Demonstration Program, do you plan to transfer funds from central to decentralized levels (provinces, districts etc.)? If yes, how will this funds transfer be executed and controlled? | | Yes. Funds will be transferred from the central level to the regional level  The transfer will be from WHO to the appropriate RDH | | |
| * Does the implementing entity keep adequate records of financial transactions, including funds received and paid, and of the balances of funds held? | | Yes | | |
| * How often does the implementing entity produce interim financial reports? | | Statements are produced monthly and audit reports are produced annually. | | |
| * Are the annual financial statements audited by an external audit firm or Government audit institution (e.g. Auditor General Department)? | | Yes, an outside audit firm is recruited every year to perform an audit of all Ministry of Health financials (including GAVI) | | |
| ***5. Information about procurement management arrangements for the GAVI HPV Demo Program:*** | | | |  |
| * What procurement system is used or will be used for the GAVI HPV Demo Program? | | The procurement system will be compatible with the system that is already in place:  Vaccine orders will be made via the intermediary of UNICEF, after the vaccines have been received, the regional level will directly supply the two districts involved | | |
| * Does the recipient organization have a procurement plan or will a procurement plan be prepared for this HPV Demo Program? | | Yes | | |
| * Is there a functioning complaint mechanism? | | YES | | |
| * What is the staffing arrangement of the organization in procurement? Does the implementing entity have an experienced procurement specialist on its staff? | | There is already staff for this in the field and there is a procurement specialist in the immunization unit | | |
| * Are there procedures in place for physical inspection and quality control of goods, works, or services delivered? | | YES | | |

1. Signatures

9.1. Government

The Government of Mali acknowledges that this Program is intended to assist the government to determine if and how it could implement HPV vaccine nationwide. If the Demonstration Program finds HPV vaccination is feasible (i.e. greater than 50% coverage of targeted girls) and acceptable, GAVI will encourage and entertain a national application during the second year of the Program. Application forms and guidelines for national applications are available at [www.gavialliance.org](http://www.gavialliance.org/). The data from the Demonstration Program and timing of a national application are intended to allow uninterrupted provision of vaccine in the demonstration district and nation-wide scale-up.

The Government of Mali would like to expand the existing partnership with the GAVI Alliance for the improvement the health of adolescent girls in the country, and hereby requests for GAVI support for an HPV Demonstration Program.

The Government of Mali commits itself to improving immunization services on a sustainable basis. The Government requests that the GAVI Alliance and its partners contribute financial and technical assistance to support immunization of targeted adolescent girls with HPV vaccine as outlined in this application.

The Government of Mali acknowledges that some activities anticipated in the demonstration program could be considered research requiring approval by local ethics committees (e.g., collecting data from a random sample of parents of eligible girls for the HPV vaccine coverage survey). We acknowledge we are responsible for consulting and obtaining approval from appropriate local ethics committees (e.g., human subject protection committee or Institutional Review Boards) in our country, as required. By signing this application, the Government of Mali and the TAG members acknowledge that such approval may be necessary and that it will obtain such approval as appropriate.

The table in Section 6 of this application shows the amount of support requested from the GAVI Alliance as well as the Government of Mali's financial commitment for the HPV Demonstration Program.

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.

**Q32.** Please provide appropriate signatures below.

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
| **Minister of Public Health and Hygiene/ PO**  **Secretary General** | | **Minister of National Education/ PO**  **Secretary General** | |
| **Name** | [Prof. Adama Diawara] | **Name** | [Mr. Souleymane Goundiam]  *Chevalier de l'ordre national* |
| **Date** |  | **Date** |  |
| **Signature** |  | **Signature** |  |

**Q33.** This application has been compiled by:

Enter family name in capital letters.

Table XVI: List of individuals participating in the preparation of this application (see list of participants).

| **No.** | **Family name(s)** | **First name(s)** | **Structures**  **/departments** | **Contacts** | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Malitel** | **Orange** | **Email** |
| 1 | Dr. Maiga | Oumou Diakite | NDH | 66 71 79 87 | 76 08 68 20 | [dkiteoumou24@yahoo.fr](mailto:dkiteoumou24@yahoo.fr) |
| 2 | Dr. Kone | Nouhoum | NDH | 66 72 39 07 | - | [nkone63@yahoo.fr](mailto:nkone63@yahoo.fr) |
| 3 | Dembele | Rokiatou Diakite | CVD/CNAM | 66 98 77 95 | 73 28 84 42 | [rokiad205@gmail.com](mailto:rokiad205@gmail.com) |
| 4 | Mr. Dembele | Karamoko | MEAPLN/DNP | 63 62 15 98 | 76036083 | [kdembele53@yahoo.fr](mailto:kdembele53@yahoo.fr) |
| 5 | Mr. Diaby | Bani | SI/NDH | 66 85 57 55 | 76416169 | [diabyseptembre@yahoo.fr](mailto:diabyseptembre@yahoo.fr) |
| 6 | Prof. Diallo | Souleymane | CICM | - | 76433800 | [souleymane.diallo@cicm-mali.org; ntjisdiallo@yahoo.fr](mailto:souleymane.diallo@cicm-mali.org,) |
| 7 | Dr. Diarra | Nazoum J.P. | NDH/NTD | 66 78 19 47 | 79 40 64 68 | [dnazoum@yahoo.fr](mailto:dnazoum@yahoo.fr) |
| 8 | Fofana | Soula Goita | NDH | 66 90 62 55 | 76 21 80 22 | [fofsoula@yahoo.fr](mailto:fofsoula@yahoo.fr) |
| 9 | Mr. Goita | Issa | DNPF | 66 53 14 00 | - | [isacbadra1@yahoo.fr](mailto:isacbadra1@yahoo.fr) |
| 10 | Dr. Maiga | Aguissa | NDH/DPLM/SI | - | 76248904 | [amagaml@yahoo.fr](mailto:amagaml@yahoo.fr) |
| 11 | Dr. Konandji | Mariam Sissoko | UNICEF | 66 92 89 59 | 76 32 16 67 | [msissoko@unicef.org](mailto:msissoko@unicef.org); mariamkonandji@yahoo.fr |
| 12 | Dr. Niare | Fanta Dembele | CVD/CNAM | 76 45 89 79 | 60 55 52 54 | [niare63@yahoo.fr](mailto:niare63@yahoo.fr) |
| 13 | Mr. Sidibe | Mahamadou | DGB/Ministry of Finance | 69 03 88 33 | 79 03 88 33 | [m\_sidibe86@yahoo.fr](mailto:m_sidibe86@yahoo.fr) |
| 14 | Dr. Sylla | Mala | Sikasso Hospital | 66 69 00 42 | 76 21 58 19 | [hamasylla@yahoo.fr](mailto:hamasylla@yahoo.fr) |
| 15 | Dr. Toure | Attaher | WHO/Mali | 66 96 46 72 | 75235353 | [tourea@ml.afro.who.int](mailto:tourea@ml.afro.who.int) |
| 16 | Prof. Traore | Cheick Bougadari | HUC-Point ''G'' | 66 73 63 23 | 75 15 29 03 | [cheickbtraore@yahoo.fr](mailto:cheickbtraore@yahoo.fr) |
| 17 | Ms. Wague | Sirantou | NDH/DSR | 66 91 31 31 | 76 42 78 29 | [sirantou2011@yahoo.fr](mailto:sirantou2011@yahoo.fr); [sirantouwague@sante.gov.ml](mailto:sirantouwague@sante.gov.ml) |
| 18 | Mr. Yalcouye | Idrissa | WHO/Mali | 66 72 39 65 | 76 18 33 80 | [yalcouyei@ml.afro.who.int](mailto:yalcouyei@ml.afro.who.int) |
| 19 | Dr. Tounkara | Baba | WHO/Mali | 66 79 91 72 | 75 24 68 01 | [tounkarab@ml.afro.who.int](mailto:tounkarab@ml.afro.who.int) |
| 20 | Traore | Mariam Sidibe | UNICEF/C4D | 66 73 14 32 | - | [masidibe@unicef.org](mailto:masidibe@unicef.org) |
| 21 | Dr. Dicko | Alassane Balobo | NDH/DPLM | 65 80 72 89 | 76 12 82 67 | [alassanebalobo10@yahoo.fr](mailto:alassanebalobo10@yahoo.fr) |
| 22 | Dr. Kamissoko | Mady | NDH/DPLM/SI | 66 76 70 42 | - | [kamissoko\_mady11@yahoo.fr](mailto:kamissoko_mady11@yahoo.fr) |
| 23 | Dr. Konate | Famoussa | NDH/DPLM/SI | 62 28 78 51 | 76 48 41 58 | [famoussa10@ymail.com](mailto:famoussa10@ymail.com) |
| 24 | Mr. Kouyate | Seydou | NDH/DPLM/SI | 66 33 62 48 | 76 48 14 40 | [sykouyate2007@yahoo.fr](mailto:sykouyate2007@yahoo.fr) |
| 25 | Mr. Bathily | Moussa | NDH/DPLM/SI | 62 68 75 69 | 76 32 66 49 | [bathily.moussa@yahoo.fr](mailto:bathily.moussa@yahoo.fr) |
| 26 | Dr. Berthe | Ouassa | NDH/DPLM/SSE | 66 82 26 01 | 79 34 10 23 | [ouassa.berthe@yahoo.fr](mailto:ouassa.berthe@yahoo.fr) |
| 27 | Diarra | Assetou Kamate | Stop WHO Consultant | - | 90 79 27 42 | [kamatea@ml.afro.who.int](mailto:kamatea@ml.afro.who.int) ; [kdassetou@gmail.com](mailto:kdassetou@gmail.com) |
| 28 | Dr. Kodio | Mamoudou | CVD/CNAM | 66 94 98 38 |  | [ogodana@hotmail.com](mailto:ogodana@hotmail.com) |
| 29 | Prof. Bougoudogo | Flabou | INRSP/FAPH | 66 74 85 42 | 76 16 51 52 | [flabou@hotmail.com](mailto:flabou@hotmail.com) |
| 30 | Dr. Traore | Sékou | INRSP | 66 77 02 73 | 76 49 47 48 | [sektra2002@yahoo.fr](mailto:sektra2002@yahoo.fr) |
| 31 | Mr. Diarra | Gaoussou | DFM/Health | 66 94 07 82 | - | [gadiarra1@yahoo.fr](mailto:gadiarra1@yahoo.fr) |
| 32 | Dr. Dembele | Ousmane | DRS/Sikasso | 66 79 69 55 | 79 31 47 07 | [ousma66@yahoo.fr](mailto:ousma66@yahoo.fr) |
| 33 | Dr. Traore | Dramane | DRS/Sikasso | 66 84 54 67 | 76 15 70 46 | [dramanegss@yahoo.fr](mailto:dramanegss@yahoo.fr) |
| 34 | Mr. Hama | Abdoulaye | DNDS | 65 36 60 11 | 76 33 39 86 | [hamamaigaa@yahoo.fr](mailto:hamamaigaa@yahoo.fr) |

| **No.** | **Family name(s)** | **First name(s)** | **Structures**  **/departments** | **Contacts** | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Malitel** | **Orange** | **Email** |
| 35 | Mr. Modibo Maiga | Harouna | NDH/DPLMSI | 66 73 62 33 | 78 43 13 64 | [haroun.affoudou@yahoo.fr](mailto:haroun.affoudou@yahoo.fr) |
| 36 | Mr. Traore | Souleymane | CNIECS | 66 80 39 86 | 74 40 06 84 | [souleymaneseydoutraore@yahoo.fr](mailto:souleymaneseydoutraore@yahoo.fr) |
| 37 | Dr. Diallo | Yacouba L. | HUC-Point ''G'' | 69 29 30 15 | 70 51 99 17 | [yldialloml@gmail.com](mailto:yldialloml@gmail.com) |
| 38 | Mr. Keita | Bobo | UNICEF Consultant | 66 73 63 54 | 76 72 02 71 | [boboprotos@yahoo.fr](mailto:boboprotos@yahoo.fr) |

* 1. National Coordinating Body – Inter-Agency Coordinating Committee (ICC) for Immunization

**Q34.** We the members of the ICC, HSCC, or equivalent committee met on [10 September] 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 DOCUMENT NUMBER : [appendix #4].

Enter family name in capital letters.

|  |  |  |
| --- | --- | --- |
| **Name/Title** | **Agency/Organization** | **Signature** |
| [Prof. Adama Diawara, Secretary General] | [Ministry of Health] |  |
| [Dr. Mamadou Namory Traore, Technical Public Health Advisor] | [Ministry of Health] |  |
| [M. Souleymane Traore, Director] | [Directorate of Financial and Material Resources] |  |
| [Dr. Diakite Oumou Soumana Maiga, National Director] | [National Department of Health] |  |
| [Mahamadou Sidibe, Application Manager] | [Department of the General Budget] |  |
| [Dr. Fall Ibrahima-Socé, WHO Representative] | [WHO] |  |
| [Françoise Ackermans, UNICEF Representative] | [UNICEF] |  |
| [Ms. Carrie Rasmussen, PI du Bureau 202 Director] | [USAID] |  |
| [Dr. Aliou Abdoulaye Maiga, President] | [Rotary International] |  |
| [Ms. Dembele Nene Kane] | [Lion’s Club] |  |
| [Souleymane Dolo, President] | [Pivot Santé / Population Group] |  |
| [Prof. Samba Sow, Director of CNAM] | [CDV - CNAM] |  |
| [Dr. Olivier Evreux, Health Advisor] | [French Embassy] |  |
| [Ms. Fadimata Alaincha, Director] | [Mali Plan] |  |
| [Dr. Sidibe Fatoumata Maguiraga, PI Director] | [CNIECS] |  |

**Q35.** In case the GAVI Secretariat has queries on this submission, please contact:

Enter family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Dr. Aguissa Mohamane Maiga | **Title** | [Head of Immunization Unit] |
| **Telephone no.** | [223 20 22 39 20] |
| **Fax no.** | [223 20 22 77 99] | **Agency** | [National Department of Health] |
| **Email** | [cni@afribonemali.net, amagaml@yahoo.fr] | **Address** | [N’Tomikorobougou – Bamako – BP: 51] |
| **Mobile no** | [+223 76 24 89 04] |

1. Optional supplementary information

**Q36.** (***optional***) If available, countries may provide additional detail in the table below on training content, role, and framework.

|  |  |  |  |
| --- | --- | --- | --- |
| **Who will be trained** | **Role in vaccine delivery**  *sensitization, mobilization, immunization, supervision, monitoring, etc.)* | **Training content**  *(e.g., basics on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring, etc.)* | **Who will provide the training?** |
| Health workers | [Insert text] | [Insert text] | [Insert text] |
| Supervisors | [Insert text] | [Insert text] | [Insert text] |
| Teachers | [Insert text] | [Insert text] | [Insert text] |
| School officials | [Insert text] | [Insert text] | [Insert text] |
| District leaders | [Insert text] | [Insert text] | [Insert text] |
| Other: | [Insert text] | [Insert text] | [Insert text] |
| Other: | [Insert text] | [Insert text] | [Insert text] |
| Other: | [Insert text] | [Insert text] | [Insert text] |

**Q37.** (***optional***) If available, countries may provide additional detail in the table below on the types of information and/or materials that may be used/disseminated, to which audience, by which mechanism, and the frequency of each.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of information and materials**  *(e.g., leaflet, poster, banner, handbook, radio announcement, etc.)* | **Audience receiving material**  *(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 program starts, etc.; day of vaccination, two weeks before program begins, etc.; )* |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| [Insert text] | [Insert text] | [Insert text] | [Insert text] | [Insert text] |

**Q38.** (***optional***) Technical partners (e.g. local WHO staff) are required to participate in planning and conducting the evaluation of HPV vaccine delivery. Please specify if such (an) expert(s) already exist on the country team (name, title, organization). Alternatively, or in addition, an international participant can be requested through technical partners if additional expertise is thought necessary.

[Insert text]

**Q39.** (***optional***) In the table below, countries can provide a brief summary of the current adolescent health services or interventions and health education activities and implementing agencies in the district selected to implement the HPV Demonstration Program.

Please add additional tables if necessary.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **intervention** | **intervention** | **intervention** | **intervention** |
| Description of intervention | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Agency and provider delivering the intervention | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Target population by age, grade, and sex | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Number and types of facilities implementing | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Geographic location(s) of the intervention (where in the country) | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Timing of the intervention (when) | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Frequency of the intervention (how often) | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Coverage of the target population (recent year) | [Insert text]  year [Type text]  source of data [Type text] | [Insert text]  year [Type text]  source of data [Type text] | [Insert text]  year [Type text]  source of data [Type text] | [Insert text]  year [Type text]  source of data [Type text] |
| Coordinating agency | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Collaborating partners | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Implementation costs of the intervention, if known | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Funding source, if known | [Insert text] | [Insert text] | [Insert text] | [Insert text] |
| Data source(s) for the information on each intervention | [Insert text] | [Insert text] | [Insert text] | [Insert text] |

**Q40.** (***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 Demonstration Program. If available, countries can include information on target populations, delivery structure, and funding sources.

Table XVII: Current cervical cancer service treatments and prevention.

|  |  |  |
| --- | --- | --- |
| **Intervention focus** | **Strategies** | **Implementation entities** |
| Primary prevention | Sensitization | NGOs, Ministry of Health, Partners. |
| HPV immunization | CVD-CNAM |
| Secondary prevention | Screening | ComHC, RefHC, National and secondary hospitals, religious entities and private clinics. |
| Tertiary prevention | Treatment of precancerous and cancerous lesions | RefHC, National and secondary hospitals, religious entities and private clinics. |

**Q41.** (***optional***) Describe the plan for securing Ministry of Health approval of the draft national cervical cancer prevention and control strategy and any activities for dissemination to national, sub-national, and/or local partners and stakeholders.

The document has been developed by request of the Minister of Health by the National Department of Health Direction for his approval.

**Q42.** (***optional***) If known, please indicate the representatives of the TAG that will be involved in the assessment of the feasibility of integrating selected adolescent health interventions with delivery of HPV vaccine.

Enter family name in capital letters.

Table XVIII: If known, please indicate the TAG representatives who will be involved in assessing the feasibility of integrating health data interventions

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name/Title** | **Agency/Organization** | **Area of Representation** |
| ADH interventions TAG member involved in assessment of ADH interventions | [Insert text] | [Insert text] | [Insert text] |
| ADH interventions TAG member involved in assessment of ADH interventions | [Insert text] | [Insert text] | [Insert text] |
| ADH interventions TAG member involved in assessment of ADH interventions | [Insert text] | [Insert text] | [Insert text] |
| ADH interventions TAG member involved in assessment of ADH interventions | [Insert text] | [Insert text] | [Insert text] |
| ADH interventions TAG member involved in assessment of ADH interventions | [Insert text] | [Insert text] | [Insert text] |

**Q43.** (***optional***) If known, please indicate the representatives of the TAG that will be involved in the development or revision of a draft national cervical cancer prevention and control strategy.

Enter family name in capital letters.

Table XIX: If known, please indicate the representatives of the TAG that will be involved in the development or revision of a draft national cervical cancer prevention and control strategy.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name/Title** | **Agency/Organization** | **Area of Representation** |
| TAG member involved in cervical cancer strategy | [Insert text] | [Insert text] | [Insert text] |
| TAG member involved in cervical cancer strategy | [Insert text] | [Insert text] | [Insert text] |
| TAG member involved in cervical cancer strategy | [Insert text] | [Insert text] | [Insert text] |
| TAG member involved in cervical cancer strategy | [Insert text] | [Insert text] | [Insert text] |

**Q44.** (***optional***) If present, please describe the distribution of de-worming medication (anti-helminths) in the district(s).

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1** [Insert text] name | **District 2 (as applicable)** [Insert text] name |
| Organization of the de-worming program | [Insert text] | [Insert text] |
| Lead agency | [Insert text] | [Insert text] |
| Implementing agency and partners | [Insert text] | [Insert text] |
| Funding source(s) | [Insert text] | [Insert text] |
| Frequency and timing of implementation, e.g. twice yearly in March and October | [Insert text] | [Insert text] |
| Number in target population by age group and sex | [Insert text], data source [Insert text] | [Insert text], data source [Insert text] |
| De-worming coverage by age group and sex | [Insert text], data source [Insert text] | [Insert text], data source [Insert text] |

**Q45.** (***optional***) If present and relevant, please describe any organized semi-annual health days (e.g., Child Health Days) that are currently implemented in the district(s).

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1** [Insert text] name | **District 2 (as applicable)** [Insert text] name |
| Organization of the semi- annual health days | [Insert text] | [Insert text] |
| Lead agency | [Insert text] | [Insert text] |
| Implementing agency and partners | [Insert text] | [Insert text] |
| Funding source(s) | [Insert text] | [Insert text] |
| Frequency and timing of implementation, e.g. twice yearly in March and October | [Insert text] | [Insert text] |
| Services delivered | [Insert text] | [Insert text] |
| Number in target population by age group and sex | [Insert text], data source [Insert text] | [Insert text], data source [Insert text] |
| Coverage of the different services delivered by age group and sex | [Insert text], data source [Insert text] | [Insert text], data source [Insert text] |

**Q46.** (**optional**) If present, please describe any organized health education programs implemented at schools and/or in the community that are currently implemented in the district(s).

|  |  |  |
| --- | --- | --- |
| **Component** | **District 1**  [Insert text] name | **District 2 (as applicable)** [Insert text] name |
| Organization of the health education program | [Insert text] | [Insert text] |
| Lead agency | [Insert text] | [Insert text] |
| Implementing agency and partners | [Insert text] | [Insert text] |
| Funding source(s) | [Insert text] | [Insert text] |
| Frequency of services, e.g. once a month, weekly, etc. | [Insert text] | [Insert text] |
| Services delivered | [Insert text] | [Insert text] |
| Location(s) of service delivery | [Insert text] | [Insert text] |
| Number in target population by age group and sex | [Insert text], data source [Insert text] | [Insert text], data source [Insert text] |
| Coverage of the different services delivered by age group and sex | [Insert text], data source [Insert text] | [Insert text], data source [Insert text] |

**Q47.** (**Optional**) Please describe if the country intends to conduct other research activities at the same time as the demo program, using other funding sources.

* Monitoring Adverse Effects Following Immunization (AEFI) during immunization with HPV vaccines in the two health districts in Mali (CVD-CNAM).
* Epidemiological study on the prevalence infection by HPV in urban and rural areas in Mali (Anatomico-pathological Laboratories and Hematology and Medical Oncology Department HUC Point ‘’G’’- via DSR).
* Impact of migration flows on the prevalence of HPV infection in the Sikasso and Koulikoro regions (DRS-via DSR). .
* CAP study on cervical cancer in Mali (anthropologists, psychologists, oncologists) via DSR.

# References:

1. Bayo, S., et al., *Risk factors of invasive cervical cancer in Mali.* International journal of epidemiology, 2002. **31**(1): p. 202-9.

# Appendices:

Appendix 1: cMYP

Appendix 2: Costing tool

Appendix 3: Outil Epi\_Log\_Forcasting\_Tool

Appendix 4: Minutes of ICC meetings