Q&A for Mini-cPIE Clinic #02: Country Experience Sharing and Lessons Learned

Tuesday, 21 September 2021

Thank you for attending the above mini-cPIE clinic session for countries and partners. Please see below consolidated questions and answers from the session for your reference from Ghana and Uganda presenters.

GENERAL QUESTIONS REGARDING MINI-CPIE

What is the advantage of conducting a mini-cPIE over a full cPIE while we already have an intra-action review (IAR)?

The mini-cPIE is the vaccination pillar (pillar 10) of the intra-action review (IAR). The questions for this pillar are focused on COVID-19 vaccination. The COVID-19 vaccination IAR or mini-cPIE is recommended early in the post-introduction phase (2-6 months), whereas the full cPIE is recommended 6-18 months after introduction. However, with the COVID-19 vaccination IAR or mini-cPIE being a lighter and easier process to implement, it is also possible to do more than one when countries wish to review specific aspects of the COVID-19 vaccine roll-out as the contexts evolve.

QUESTIONS FOR GHANA

How long was the CEM conducted and how many sites were involved?

The CEM started in March 2021 and was expected to end in October 2021. With the introduction of new COVID-19 vaccines (Moderna), additional sites have been added and the period has been extended. Three sites (health facilities) were included.

What is the cost associated with affixing holograms on vaccination cards?

Affixing the hologram on vaccination cards was $0.03 and represented 10% of the cost of the vaccination card.

Kindly share how Ghana handled allowances for the vaccination teams.

Ghana does not pay allowances for COVID-19 vaccine deployment. We, however, give a token to vaccinators, volunteers and supervisors to cater for food, water and incidentals (approximately $10 per day).

Kindly share strategies used for vaccines that are very near their shelf life.

Ghana employs a campaign strategy for COVID-19 vaccines, which makes it possible for large volumes of vaccines, including those with short shelf-life, to be consumed within a short time. However, the challenge is that there is little room for planning and microplanning.

Who was involved in the mini-cPIE?

The IAR was an interactive and participatory process that involved all partners and stakeholders. Key actors from each region were invited, and we allowed more time for discussions, group work and plenary sessions.

Which vaccines have been delivered so far? Which new vaccines are coming up? Are you using multiple vaccines at the same time?

We have used AZ (Covishield and Vaxzevria), J&J, and Sputnik-V so far. We currently have received Moderna and are about to deploy this. We have EUA for Pfizer, which is expected to arrive in the next month.

Could you explain how the EOC works? Which data is used and what kind of decisions are taken?

The Vaccination Sub-EOC uses real-time data from e-monitoring tools specifically designed for COVID-19 vaccine deployment. Data from the e-registry is also analyzed and findings are shared with all respective levels in real-time. The dashboards are accessible to all.

Is there still an operational funding gap now?

There is still a huge funding gap for the COVID-19 vaccine roll-out. We are doing our best to bridge the gap through high-level advocacy with all concerned.

Is there a medium or long-term plan to incorporate the learnings and results in the routine immunization program? If yes, what are the key areas?

The country is yet to have a holistic view of the response and explore how it could impact routine immunization going forward. Electronic data entry for transactional data is on our agenda.

How do you see the effect of the COVID-19 vaccination campaign on routine immunization coverage and how do you manage it?

The country is yet to have a holistic view of the response and explore how it could impact routine immunization going forward.

QUESTIONS FOR UGANDA

What strategies are you using to reach people who can't make it to the vaccination sites (people with disabilities, elderly…etc.?

In Uganda, we are using mobile outreaches to bring services closer to the elderly. We work closely with the Village Health Teams to ensure that these are assembled in one central point; we are also exploring the use of special clinics to offer the service.

In reviewing COVID-19 operational financing - did you encounter a delay in funds deployment or funds getting to the operational level? How did you resolve this?

From the very beginning of the roll-out, we did not have funds to support operational activities; resource mobilization was done during the actual roll-out. Once the funds were received, these were sent out to the districts to use their own system to access the funds. This meant arrears were paid to the health workers. Health workers were informed about the delays and hence they waited patiently. The key lesson is to communicate to beneficiaries in time and encourage them to continue offering the services as administrative issues are being resolved.

Have you experienced any severe AEFI and how do you manage the communication and vaccine hesitancy after it?

Yes, we have registered severe AEFIs in particular deaths. But with investigations done, including post-mortem, the cause of deaths was determined as coincidental and unrelated to vaccines.

How do you see the effect COVID-19 vaccination campaign on routine immunization coverage and how do you manage it?

Fortunately, the number of doses received for COVID-19 are very minimal to grossly interfere with provision of services at the operational level. Health workers have continued to provide other services, including routine immunization. The biggest impact is usually observed during the lockdown, but once restrictions are released in particular transport services, the routine immunization activities resume and catch up is achieved.

Are the days for COVID-19 vaccination fixed with the remaining days utilized for routine immunization?

The COVID-19 vaccination campaigns occur when we receive more doses in the country and these go on concurrently with routine immunization. We use only a maximum of 10 vaccination teams per district, which means that other health workers can continue to provide essential services.

Many things related to data capture and analysis have been performed within NVDP: Electronic registries, QR code, interactive Dashboard, AEFI surveillance… How could all these benefit routine immunization activities?

The main benefit is linking the e-register to the DHIS2. That is what we are doing now for routine immunization in a phased manner using SMART paper technology to generate e-registers and hence upload onto the DHIS2. This will help us to estimate our target population and also track defaulters.

South Africa has a school-based HPV vaccination campaign. We have seen misinformation circulating that the Government is now targeting school children with the COVID-19 vaccine, and parents were not signing consent forms for their children to be vaccinated. Are there other countries administering the HPV vaccine to learners? If so, did you have any challenges and how did you handle this?

We have not had any major issues with HPV vaccination through questions around signing consent forms. However, communication is key, and we have been informing the communities that these are EUL approved vaccines. Benefits and risks are also shared with them so that voluntary decisions can be made regarding the receipt of the vaccine. But for prequalified vaccines obtaining consent will not be a requirement.

Due to the conflicting activities that engulf the COVID-19 vaccine implementation, did you consider integrating activities? Could you highlight more on integration strategies?

Uganda has a pillar focusing on the continuity of essential services, and guidelines were developed and disseminated to all districts to ensure that COVID-19 response does not interfere with other services. Routine HMIS data has shown this and is a good tool that guided us on what measures should be put in place. We are currently undertaking a study documenting the mitigation measures put in place to address the impact of COVID-19 on five vulnerable populations to help us address the issues in the future.

How did you address vaccine hesitancy among health workers?

Continuous engagement and having question and answer sessions were key. We should respond to their concerns and provide all the scientific evidence required. Secondly, the top leadership of the medical professional bodies was also key in providing information to the health workers.

How did you address data flow during the COVID-19 vaccine roll-out?

We had a well-facilitated team at the district level in terms of human resources, materials (tablets/laptops, internet) and financial resources to conduct real-time data entry, plus hard copies of tools used to capture the data.

How did you reassure beneficiaries regarding fake vaccines issues?

Continuously provide accurate information and emphasizing the need to ensure that the community access vaccines from designated vaccination service points. Also, remind them that it would be at their own risk if they went outside those sites.

How did you engage with the private sector?

This is still being discussed. However, PNFP health facilities are provided with vaccines and offer the services, but the private sector bringing in vaccines has not yet been opened up.