Supporting new vaccine introduction decisions: Lessons learned from the Hib Initiative experience


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1. Introduction

The introduction of Haemophilus influenzae type b (Hib) vaccine in developing countries has suffered from a long delay. Between 2005 and 2009, a surge in Hib vaccine adoption took place, particularly among GAVI-eligible countries. Several factors contributed to the increase in Hib vaccine adoption, including support provided by the Hib Initiative, a project funded by the GAVI Alliance in 2005 to accelerate evidence-informed decisions for use of Hib vaccine. This paper reviews the strategy adopted by the Hib Initiative and the lessons learned in the process, which provide a useful model to accelerate uptake of other new vaccines.

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and policy-support, and utilized the global mandate of WHO and its network of regional and country offices to provide direct support to ministries of health. Building on lessons learned from the introduction of other vaccines, principally hepatitis B, the HI developed a strategic plan to address the key barriers for introduction. The plan focused on three areas that were determined critical to overcome the barriers for vaccine introduction—communications and advocacy, research and surveillance, and coordination of programmatic activities such as finance, supply and vaccine logistics. This paper reports on the experience and approach of the HI and the many lessons learned in implementing its strategy, hoping that these lessons will be useful for ongoing efforts to introduce other new vaccines.

2. Communications and advocacy

2.1. Understanding the problem and designing strategies

The main objective of the HI communications strategy was to ensure that decision-makers and other stakeholders had timely access to evidence that was relevant and understandable, to inform decisions for Hib vaccine introduction. Early in the project, the HI determined what evidence was needed or perceived important for decision making. This was accomplished by discussions with WHO regional office staff; visiting countries considered to be strategically important for the region; conducting country consultations, and interacting with representatives from countries at various meetings; subsequently, formative research was conducted in different regions. Decision making by national authorities appeared to be strongly influenced by the perceived level of disease burden: e.g. in Asian or Eastern European countries where burden data was limited, Hib disease was seldom considered a problem and routine vaccination was not a priority. Direct meetings with authorities in these countries, in particular involving local or regional physicians and experts, were critical to communicate key messages and clarify nuances of relevant studies. Furthermore, although pneumonia was consistently the first or second child health concern in all regions, Hib was rarely recognized as a major cause of pneumonia; Hib vaccines were infrequently recognized as relevant for reducing child mortality and reaching Millennium Developmental Goal 4. The HI customized its communications strategy based on regional perceptions, and created a sense of urgency by demonstrating the health and societal costs of delays in decisions. Participants of regional advocacy training workshops provided valuable input into development of materials and noted that group work, in particular, helped make their advocacy more effective and learned from fellow participants.

2.2. Packaging and disseminating evidence

The HI communications staff worked closely with its technical staff to develop presentations, policy briefs, research summaries, and press releases in order to ensure that new evidence could be widely communicated beyond the usual research forums and academic circles. Multiple mechanisms were used to disseminate information and address key concerns: country consultations, academic and technical meetings and conferences, advocacy training workshops, mainstream media, as well as the HI newsletter and website (www.HibAction.org). One approach that proved to be particularly effective was the organization of multiple regional forums early in the HI, including two for Africa (one each for English-speaking and French-speaking countries), and one for each of the Eastern Mediterranean, Asian and European regions. These forums brought together multiple stakeholders, including ministry of finance officials who have not traditionally been invited to such meetings, as well as national, local, and regional technical experts, senior staff and policy-makers from ministries of health and regional partners, thus creating professional networks for evidence and policy sharing. In the African region in particular, where studies had already documented the high disease burden and the dramatic impact of Hib vaccine in early-introducing countries, these forums generated a significant momentum among national decision-makers, and resulted in a large number of GAVI applications shortly afterwards. Local champions such as pediatricians and journalists were central to communication and advocacy. To strengthen the communications and advocacy skills of these local champions, the HI held regional training workshops, supplementing it with a small grants program to help participants implementing their ideas (e.g. meetings, media activities—radio programs, editorial articles, etc.), and provided support for pediatric societies and civil societies to promote community awareness. Multiple lessons were learned from the implementation of the communications and advocacy strategy and are summarized in Panel 1. Case studies 1, 2, 3 and 6 help illustrate some of these lessons. In retrospect, most approaches that we planned to use initially worked well — the most important gap was probably lack of preparation for the anti-vaccine lobby. Training and a specific strategy to deal with negative criticism, particularly in India, would be important for future work. A significant amount of time was spent reacting to sensationalist media, which when put in the media tended to draw even more unwanted attention. Proactively addressing the value of vaccination and showing the human face of disease are better strategies to deal with these claims.

Panel 1: Advocacy and communications lessons learned

<table>
<thead>
<tr>
<th>Approach</th>
<th>Lessons learned</th>
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<tr>
<td>• Link decision-makers and partners to accessible and relevant evidence to inform decisions on Hib vaccine introduction and place in within the larger context of child survival activities.</td>
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<td>o Build a trusting relationship with country decision-makers through personal contacts, evidence-informed approach and improved communication.</td>
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<td>o Support country-led approaches to advocacy and communication and provide trained advocates with tools and support to be effective.</td>
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<td>o Provide evidence to EPI program managers and their counterparts in key partner agencies, as well as various stakeholders and decision-makers at various levels and ministries.</td>
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<td>o Link Hib vaccine to the broader/more visible context of child survival and pneumonia control.</td>
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<td>o Develop clear and consistent messages about evidence, including disease burden data, but also cost-effectiveness, financing and supply, programmatic issues and potential impact.</td>
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<tr>
<td>o Prepare for the anti-vaccine lobby through media and advocacy training, and proactive strategies to address value of vaccination.</td>
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3. Research and surveillance

By the time the HI started, a significant amount of data existed on Hib disease burden and vaccine efficacy and impact globally. It was also obvious that, except for economic analyses, most new studies could not be started and finished in time to affect the decision mak-
ing process during the life of the HI project. Therefore, the research strategy of the HI mainly focused on addressing gaps in Hib knowledge, and supporting research and surveillance activities that could provide evidence and capacity to sustain vaccine programs beyond the period of GAVI support. These included vaccine effectiveness studies, surveillance systems and studies to model disease burden, economic studies, as well as studies to evaluate programmatic impact of vaccine introduction. To address knowledge gaps, studies were supported to assess the impact of Hib vaccine in Ethiopia to have more data from the Horn of Africa, in Pakistan and Bangladesh to provide data on vaccine impact in South Asia, and in Vietnam to provide impact data from the Mekong Valley countries. In addition, studies were started in Mozambique to better understand the impact of Hib vaccination in populations with high HIV prevalence, and in the Gambia, an early-introducing country of Hib vaccine, to assess whether a Hib booster dose, a common practice in developed countries, is needed in developing countries (for a full listing of all studies funded by the HI, see: www.HibAction.org). To provide highly sought after local burden of disease estimates, the HI together with PneumoAdIP supported the WHO Global Burden of Disease project to estimate burden of Hib and pneumococcal disease in children <5 years old at the global, regional and country level, using mathematical modeling methods and existing disease burden data [5]. To help build surveillance capacity and support monitoring or post-introduction evaluations of vaccine impact on disease, the HI helped establish, support or expand routine surveillance networks in most WHO regions. Whenever possible, activities built on existing infrastructure (e.g. Pediatric Bacterial Meningitis network in WHO AFRO, Bacterial Meningitis surveillance network in WHO EMRO).

In addition to data on disease burden, there was considerable interest in generating cost-effectiveness evidence to support and sustain vaccine decisions. The HI supported several country-specific analyses and reviewed the existing, published studies [6]. In order to build capacity for such analysis at country level, a web-based, interactive tool was developed to assist countries in estimating the cost-effectiveness of vaccination and the impact of vaccine on morbidity and mortality. In order to respond to country requests to measure the impact of Hib vaccine introduction not only on disease but also on the immunization program, the HI developed a post-introduction evaluation (PIE) tool that was based on a similar tool developed by WHO for hepatitis B vaccine introduction evaluation.

Multiple lessons were learned from the various research and surveillance studies that are summarized in Panel 2, with illustrative case studies 4 and 5. Due to the complexity of some of these lessons, a few issues should be highlighted: (1) For future new vaccines, it is important to anticipate data needs as early as possible: one critical challenge for Hib vaccine decisions, and for various modeling and economic analyses, was the lack of local data on burden of disease, pneumonia particularly, and inadequate diagnostics and methodologies to measure it. Though countries were encouraged to use regional and global data estimates, there was still a strong interest in local data, even when good data was available from neighboring countries with similar demographic, health and economic characteristics. (2) Country ownership of the data is very important to accelerate decision making: active participation in the studies, whether research, surveillance, economic or program evaluation, generates strong awareness of the disease and commitment to use vaccines to control it, as well as a better understanding of the importance of quality surveillance data and laboratory systems [7]. To increase country ownership, the HI required that ministries of health be fully engaged in all studies, especially when the primary investigators were based on local academic institutions. (3) There is a significant delay in getting research studies started in developing countries: in addition to the time it took to get all the funding mechanisms in place, many of the impact evaluation studies were dependent on vaccine introduction; it took countries an average of 9–12 months to have the vaccine procured and available after their GAVI application was approved, and about 2 years from the time a decision is made to use Hib vaccine to the time vaccine is introduced. As a result, several HI projects are ongoing through a 2-year extension from the GAVI Alliance. Future projects should allow adequate time for the full execution of research studies. (4) Programmatic evaluation is very important for planning for new vaccine introduction: though the PIEs revealed that introduction of Hib vaccine did not negatively impact the delivery of other vaccines, and that routine programs may have even been strengthened by a renewed interest in vaccination, they also revealed weaknesses in national immunization systems, most notably in the areas of health care worker training and supervision, vaccine stock and cold chain management, waste disposal and monitoring of adverse events following immunization (AEFI). Future new vaccine implementation efforts should ensure countries have adequate financial and human resources to support successful vaccine introduction.

### Panel 2: Research and surveillance lessons learned

#### Approach

- Address critical research gaps and strengthen research and surveillance capacity needed for decision making and program sustainability.

#### Lessons learned

- Anticipate research needs: Target research and surveillance activities early on towards generating quality data to help decision making, and build long-term program sustainability.
- Facilitate country ownership of research activities, with active participation of local ministries of health.
- Allow adequate time for research studies implementation, taking into account start up time and delays in vaccine introduction in countries.
- Address programmatic research needs such as impact of new vaccines on immunization programs.
- Develop clear messages about the role of surveillance, to ensure that surveillance does not become a reason for delay of vaccine introduction that attention is paid to quality of data since poor quality data can be worse than no data, and that surveillance activities are sustained and become the platform for surveillance for other communicable diseases.

### 4. Strategic coordination

The HI strived to develop a strong, focused and well coordinated team that built on the existing capacities of WHO and UNICEF at the global, regional and country level and supplement it with additional skills required to facilitate introduction of new vaccines in resource poor countries. The concerted action of all consortium members, along with the other partners, was crucial to address the various aspects relevant to decision making on vaccine introduction, including adequate financial planning, and adequate supply and logistical needs.

#### 4.1. Building a team

For full details on the organizational structure of the HI, see: www.HibAction.org. The HI included an executive committee (consisting of senior members from the participating...
institutions in the consortium), that provided strategic guidance to the project; a project director; and an operational team responsible for the implementation and monitoring of day-to-day activities, that comprised members from each of the consortium members, including technical experts in communications, epidemiology, health economics, immunization program management, as well as administrative staff. A technical advisory group (TAG) represented various regions and technical areas, and provided external oversight. The Accelerated Development and Introduction Plan (ADIP) management committee, a GAVI advisory group, provided management oversight of the HI; the HI’s project director and executive committee met with the ADIP management committee periodically, to review the project’s progress, its strategic plan as well as annual work plans and budgets. These meetings, in person or by conference calls, provided a regular opportunity to discuss various issues and modify approaches as needed.

Coordination of the consortium was facilitated by weekly operational conference calls, to get regular updates on various relevant developments, resolve problems quickly and ensure that projects remain on track. Regular face to face meetings (quarterly in the first 2 years, then every 4–6 months) were essential to establish a strong team and resolve problems. Early in the project, the HI team spent significant time discussing controversial issues such as the role of advocacy versus research, but as the project progressed and pressure increased to meet indicators and deadlines, the discussions focused more on solving practical implementation issues. The HI demonstrated that a multi-institutional international consortium can work well, but frequent interpersonal communication was crucial to developing a functional and focused team.

4.2 Programmatic activities and coordination

New vaccine focal persons supported by the HI and assigned to the WHO regional offices to coordinate and support activities in their respective regions were critical to the project’s success. Annual retreats were conducted that included the HI team, regional focal points and partners such as UNICEF, PneumoADIP and CDC Global Immunization personnel. Ongoing communication with these partners ensured consistent messaging and enhanced leveraging to solve problems.

The WHO HQ staff and regional officers played an important role supporting countries to develop their comprehensive multi-year plans (or cMYPs, a requirement of GAVI applications) and assisting with preparation of GAVI applications for new vaccines. Regional peer-review workshops for GAVI applications were valuable for countries to share lessons and provide feedback on others’ applications.

4.3 Vaccine supply

At the onset of the HI, it was felt that the existing mechanism for forecasting vaccine demand and for ensuring sufficient supply were sufficient and as such the HI did not have a significant role. However, as demand for Hib vaccines rapidly increased, especially from countries with large populations, concerns were expressed about adequate global supplies. The HI commissioned an analysis of potential global demand (including middle income markets) versus capacity, exploring the number of products available and in the pipeline and comparing it to expected timing and production capacity of manufacturers. This analysis provided an important landscape for many stakeholders and allowed modeling of price trends. For the newer vaccines, where supply uncertainties are greater, it is important to conduct long-term demand and supply analyses to complement existing short-term forecasts and tendering processes.

Another important coordination aspect was the need for a more focused approach for large countries. One such example for Hib vaccines was India, due to its complex political, administrative and geographic structures, as well as the sheer size of its birth cohort. When India expressed interest in Hib vaccines, a focused strategy was separately developed and funded to address the country’s special needs (see Case study 2). The HI team worked in India at the central level to identify and help interpret local data and studies, but also with local institutions and states to identify and train local advocates to address decision-makers, their colleagues and media (often to correct misinterpretation or misrepresentation of data in the lay press), and to generate additional data needs such as cost-effectiveness data. Building coalitions and working with Indian counterparts, who responded directly to local concerns, was very important. As the project drew to a close, the Government of India announced its decision that Hib vaccine will be introduced, and GAVI approved its application. Though this is an important milestone, it is important to ensure that India has adequate logistical support to ensure a successful and timely introduction of Hib vaccine.

Case studies 2, 3 and 6 illustrate some coordination lessons learned (the first for large countries).

Panel 3: Coordination lessons learned

Approach

- Create a strong team with multiple skill sets, and ensure adequate coordination within the team and with partners, of various program areas needed for vaccine introduction.

Lessons learned

- Create a focused team with clear goals and strategies, and establish a process for regular communication between team members.
- Set up a strategic oversight structure that encourages open and constructive debate to ensure that key issues that arise are addressed appropriately.
- Involve various sectors of decision-makers, and use opportunity of new vaccine introduction to strengthen country’s decision making capacity.
- Prepare early and carefully for steps needed to ensure smooth follow-up to a decision (application process), as well as implementation, and assist as needed.
- Understand and communicate the vaccine supply landscape.
- Large countries need additional support to address their specific vaccine decision needs.
- Ensure WHO regional offices have adequate resources and staff to coordinate and support activities in their respective regions.

5. Conclusions

The Hib Initiative built on lessons learnt from the early efforts to accelerate the introduction of hepatitis B and Hib vaccines, but also added new lessons that may be useful for future initiatives. Some of these lessons learned may seem obvious principles of project management, or a matter of “common sense”, so what is really that helped the HI implement these principles to reach its goals? In addition to the right timing and the various factors discussed earlier, we believe it is a combination of a few key elements, including the focus that the project’s brought to Hib vaccine issues, the strategic
and intense communications efforts both internally, globally and at country level with multiple stakeholders, as well as very close coordination of activities regionally.

Early vaccine experts [8] outlined in 1999 the elements needed to accelerate new vaccine introduction, such as dissemination of disease burden, cost-effectiveness and vaccine effectiveness data, international consensus, adequate vaccine supply, and funding mechanisms to support developing countries. In 2000, Wenger et al. [9] reviewed the experience of four early-introducing countries of Hib vaccine, concluding that local data and promotion of the vaccine by the local pediatric community and ministry of health were critical. In 2002, a group of disease and vaccine experts from 33 countries met in Arizona, U.S.A. to discuss how to better control Hib disease globally, and concluded that a multifaceted approach is urgently needed to overcome barriers for vaccine introduction [10]. One new lesson learned that has received little or no attention in the past was the critical importance of a good evidence-based communications and advocacy strategy and dedicated expert communications staff. The HI experience revealed that communicating clear messages about disease burden, financing, and vaccine supply and generating a sense of urgency, were very important to accelerate decision making. Another barrier for vaccine introduction used to be perceptions of lower disease burden in some countries [11], in spite of known difficulties in measuring Hib burden [10]. The HI team worked closely with country staff and officials to put the overall benefits of Hib vaccine in the context of the country’s health priorities.

In their paper describing the progress of Hib vaccination in the Americas, the PAHO team [12] commented on the importance of strong political will for countries to introduce new vaccines. The critical question is: “what does it take to generate such political will?” An earlier analysis conducted by Shearer et al. [13] revealed that countries were influenced by introduction of vaccines in neighboring countries, illustrating the importance of regional factors. For the HI project, the regional leadership of WHO was critical. In 2005, all WHO regions other than AMR had significant delays in Hib vaccine introduction, and in some regions, like EUR, not a single GAVI-eligible country had yet introduced Hib vaccine despite the full subsidy offered by GAVI at the time. Through close coordination and monitoring, WHO regional offices played a key role to ensure countries were adequately prepared to make a decision, submit a quality application to GAVI and introduce the vaccine, resulting in decisions for Hib vaccine adoption in almost all the regions (100% of all AFR, EUR, EMR and WPR GAVI-eligible countries, and 67% in SEAR).

Although significant progress has been made to increase uptake of Hib vaccine, continuous efforts are still needed to improve its global coverage. As highlighted by Ojo et al. [2], with 160 countries having introduced in 2009, still only 55% of the world’s children have access to vaccine, mostly due to delays in a few large countries. The lessons learned from the recent Hib vaccine introduction effort can be useful to the new vaccines currently available, such as pneumococcal and rotavirus vaccines, though newer vaccines may have more challenging programmatic demands than Hib vaccine for cold chain requirements, schedule of administration, supply issues and financing. Continuing to address remaining issues of vaccine delivery at the country level, strengthening routine immunization programs and assisting low middle income countries, will be crucial to improve access to new vaccines worldwide. In summary, the recent experience of the HI demonstrates that, despite various challenges, acceleration of new vaccine introduction is feasible, and that the gap in introduction between industrialized and developing countries, not only should be, but can be much shorter.

**Panel 4: A summary of lessons learned from the Hib Initiative**

1. Develop a focused team that communicates regularly and has adequate oversight.
2. Build a trusting relationship with countries through frequent communications on relevant needs.
3. Support country-led advocacy and communication among a variety of stakeholders, link Hib vaccine to child survival, and be prepared to deal with the anti-vaccine lobby.
4. Anticipate research needs for future vaccines.
5. Target research and surveillance towards data for decision making, and program sustainability.
6. Facilitate country ownership of research activities and address programmatic research needs.
7. Allow adequate time for research studies implementation, account for vaccine introduction delays.
8. Address programmatic research needs, e.g., impact of new vaccines on immunizations programs.
9. Prepare early and carefully for implementation following a vaccine introduction decision.
10. Ensure WHO regional offices have adequate resources and staff to coordinate activities.
11. Large countries need additional support to address their vaccine decision needs.
12. Develop clear and consistent messages about various evidence needs, including disease burden, role of surveillance, cost-effectiveness, financing and supply, programmatic issues and impact.

**Case studies**

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**Case study 1: Involving child survival experts in Cambodia.**

**Lesson:** Link Hib vaccine to the broader and more visible issue of child survival.

“Too often immunizations are considered a goal in themselves and not a means to achieve the goal of reducing child mortality.” Dr. Niklas Danielsson, Maternal and Child Health team leader, WHO, Cambodia.

In Cambodia, as in many Asian countries, Hib disease was not seen as an urgent public health issue by decision-makers. Cambodia’s immunization program faced many programmatic challenges, and was not considering introducing a new vaccine. However, WHO local officers recognized the important role that Hib vaccine could play in preventing child mortality, linking it to child survival, and convened a symposium on pneumonia prevention that brought together various stakeholders from the health sector. Framing Hib vaccine in the context of child survival garnered increased support, and facilitated progress towards an application to the GAVI Alliance in September 2009.
Case study 2: Leveraging existing evidence in India to reach a decision.

Lesson: Create a critical mass of high quality evidence from various sources. India has a strong history of generating and using local evidence to inform decision making. The government had planned to support a multi-site Hib vaccine probe study, but its planning was stopped in 2006, as WHO recommended global use of the vaccine. The 2-year pilot study highlighted the significant challenges and cost of a probe study, but it was still necessary to find a solution space between local stakeholders (who desired local evidence) and other partners. Despite perceptions that little data existed, multiple local studies were identified from the usual (peer-reviewed journals) and not-so-usual (dissertations, hospital records) sources, including carriage studies, immunogenicity studies, hospital-based surveillance, bacterial disease etiology investigations, and new effectiveness studies from neighboring countries that corroborated global disease burden estimates. Evidence was synthesized and presented at the National Technical Advisory Group on Immunizations (NTAGI), together with state level estimates of severe cases and deaths using mathematical models, data on cost-effectiveness, impact, pricing forecasts, and the improving supply landscape. The NTAGI assessed the local data showing Hib as an important cause of meningitis and pneumonia, the high cost-effectiveness of the vaccine and its potential impact in India, and decided to make a recommendation to the MOH to introduce Hib vaccine in India.

Case study 3: Building relationships in Nigeria.

Lesson learned: It takes time to build trusting relationships – the importance of interpersonal contacts. Over the course of the project, the HI made 142 visits to countries, including official country consultations, country visits, and research site visits. These meetings and visits built interpersonal relationships and strengthened communication and advocacy surrounding Hib vaccine adoption. Nigeria required focused attention because of its size and complexity. Initially, Nigeria was not eligible for GAVI financing for new vaccines because DTP-3 coverage was less than 50%. It was essential that policy-makers and stakeholders had access to relevant evidence on which to base a decision as coverage improved. The HI met with the Nigerian delegation several times beginning in 2007, provided in-country surveillance and laboratory consultations in 2008, and co-sponsored the Paediatric Association of Nigeria conference in 2009. The frequent interactions improved communications with national decision-makers and established a trusted relationship. Convincing about the importance of new vaccines to reach its MDG4, Nigeria applied to GAVI for Hib and pneumococcal vaccine support in May 2009.

Case study 4: Government-led surveillance in Sri Lanka results in policy change.

Lesson: Facilitate country ownership of research projects. Sri Lanka had an ongoing strong bacterial disease surveillance system coordinated by the Epidemiology Unit, MoH, and routine meetings are held to update various staff on the surveillance progress. Through the WHO local office, the HI provided technical and partial financial support to this surveillance. By late 2006, analysis of the data revealed that the incidence of Hib disease in Sri Lanka was close to 20/100,000 among children <5 years old, suggesting the need for national immunization. Sri Lanka applied for GAVI support in 2007, and introduced the vaccine in 2008. The strong links between technical and policy staff within the Sri Lankan government facilitated timely, evidence-based public health decision making.

Case study 5: Building surveillance capacity in Mongolia.

Lesson: Target research and surveillance activities towards decision making needs and building program sustainability. In 2002, UNICEF and WHO initiated a population-based active surveillance system for childhood bacterial meningitis in Mongolia. Results from 2 years of surveillance indicated significant rates of Hib, S. pneumoniae, and N. meningitidis meningitis (10). Based on these findings, Mongolia began phased introduction of pentavalent vaccine in 2005. Recognizing the potential opportunity to build upon the existing surveillance infrastructure, the Hib Initiative and PneumoADIP offered to continue supporting the surveillance system in 2007, which enabled the Government of Mongolia to measure the impact of Hib vaccine, building evidence to support a long-term investment in immunization against Hib disease, and to generate evidence needed for pneumococcal vaccine introduction.

Case study 6: The decision making process in Pakistan – importance of various stakeholders.

Lesson: Involve a diverse range of stakeholders: multisectoral government, private sector, civil society, professional societies, etc. New vaccine introductions require buy-in and support from numerous stakeholders across more than one ministry. In Pakistan, decisions to introduce a new vaccine must follow a process that involves participation from health, finance, and planning and development ministries. In 2006, the Hib Initiative visited Pakistan and met with key officials in all three ministries. While the Ministry of Health was aware of the health benefits of the vaccine, the Ministries of Finance and Planning and Development were not initially aware of disease issues or the potential role of the vaccine in meeting MDGs. Once the Ministry of Planning and Development was sensitized to the health and societal costs of Hib disease (and the benefits of prevention), they advocated to the other ministries for universal adoption. Though it is important to recognize the complexity of the decision making process in Pakistan, the Hib Initiative team helped by bringing together the important officials involved in this process, and working closely with pediatricians and immunization officers in the country, delivering clear and consistent messages.

References


