# Measles containing vaccine (MCV) presentation switches - impact, experiences, cost-effectiveness, and lessons learned…the unfolding story

20th Annual African Vaccinology Course 2025


**Details of Speaker**

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VACFA vaccines for africa

NISH National Immunization Technical Advisory Group (NITAG) Support Hub

# Presentation overview

- Background & introduction
- The ongoing MCV study in a nutshell
- Journey map: our novel value-add

# Background and Introduction

# Background

**The past**: A killer almost "killed"

- Prior to 1974…
- Continuous concerted vaccination efforts yielded great dividends –reduction in mortality and morbidity
- Measles incidence controlled and eliminated in some regions and many developed countries

**The present**: A defiant problem?

- Persistent low MCV coverage: MOVs, wastages, stockouts, and healthcare workers' and caregivers' behaviors, among other factors
- Intermittent global outbreaks and disease resurgence, often in low-and middle-income countries
- The effect of Covid-19 pandemic -interruption of NIPs globally
- Antivaxxers in power? Fake news!!!

# Problem statement

- Global estimated measles cases increased by 18% (from 7,8m to 9,2m) in the years 2021-2022 and estimated measles deaths by 43% from (95,000 to 136,200) in the same period due to the impact of the COVID-19 pandemic [1].
- In 2022, 37 countries in four WHO regions were affected by large or disruptive measles outbreaks (≥20 cases per 1 million population), an increase of 68% compared with 22 countries in two regions the preceding year. Among these 2022 outbreaks, 28 of 37 (76%) occurred in countries in the African Region [2].
- In LMICs, a significant factor that may contribute to low MCV coverage and subsequent outbreaks is the reluctance of health care workers (HCWs) to vaccinate when a small number of eligible children presents for measles vaccination [3].
- It has been estimated that if all Gavi-eligible countries switched to using MCV 5-dose vials for routine immunization, at least 2 million additional children could be reached with MCV1 each year [3].

1. Minta, A.A., Progress toward measles elimination—worldwide, 2000–2022. MMWR. Morbidity and Mortality Weekly Report, 2023. 72.
2. Nchasi, G., et al., Measles outbreak in sub-Saharan Africa amidst COVID-19: a rising concern, efforts, challenges, and future recommendations. Annals of medicine and surgery, 2022. 81.
3. Wallace, A.S., et al., Vaccine wastage in Nigeria: an assessment of wastage rates and related vaccinator knowledge, attitudes and practices. Vaccine, 2017. 35(48): p. 6751-6758.

# Potential solution under exploration

- Research conducted in Zambia found that switching to a 5-dose vial increased first dose of measles containing vaccine (MCV1) coverage by 4.9% and second dose (MCV2) coverage by 3.5% [3]
- Wastage was 47% lower in facilities using 5-dose vs. those using 10-dose vials. Wastage-adjusted vaccine price per Measles Rubella (MR) dose was only US$ 0.03 higher for 5-dose vials than for 10-dose vials.
- Moreover, HCW's reported less hesitancy to open 5-dose vials and were more likely to vaccinate children for measles outside of scheduled vaccination days when using 5-dose vials [3].
- However, more data and technical information is still required to convince, guide and support countries yet to decide or still contemplating the switch.
- This necessitates that high-quality, '**real-world**' evidence be made available to countries on the impacts, enablers and barriers associated with such a switch.

3. Wallace, A.S., et al., Vaccine wastage in Nigeria: an assessment of wastage rates and related vaccinator knowledge, attitudes and practices. Vaccine, 2017. 35(48): p. 6751-6758.

# The call

Request for proposal (RFP)

Switch Assessments for Gavi Hexavalent and MCV programs

003-2024-GAVI-RFP

ISSUE DATE: 22.01.2024

CLOSING DATE AND TIME: 01 March 2024 24:00 (CET)

# The respondent - the MISC Consortium

**VACFA/NISH South Africa**

- ✓ Extensive experience in vaccinology training on the African continent.
- ✓ Ongoing collaborations with NITAGs and academic institutions in Africa.
- ✓ Supported South African NITAG/MoH with vaccine switches in the past.

**Linksbridge USA**

- ✓ Expertise in vaccine program optimization.
- ✓ Proven track record in supporting countries undertaking the MCV DPC switch.
- ✓ Strong collaborative ties with multilateral stakeholders, including WHO and UNICEF.

**NCIRS Australia**

- ✓ Demonstrated impact in the twinning of NITAGs.
- ✓ Experienced in providing technical support and training of NITAGs at a national and regional level
- ✓ Excellence in monitoring of vaccination coverage, safety, and related matters.

# The ongoing MCV study in a nutshell…

…And emerging insights…

# Aim of our study

The aim of this study is to conduct a comprehensive impact assessment on the switch from MCV ten-dose vial to the five-dose vial presentation **prospectively** in Ethiopia and **retrospectively** in Zambia.

We seek to provide insights that will inform Evidence-Informed Decision-Making (EIDM) on MCV vial presentation switching, address gaps on the topic, and foster collaborations between NITAGs and academic institutions.

We anticipate observing a 10% increase in coverage for MCV1 and MCV2 to be associated with the MCV vial presentation switch in the poorest performing districts and a 5% increase nationally, where applicable.

# Objective 1

**Primary objective**

To measure **the impact of the MCV 10-dose to 5-dose vial switch on MCV 1 and MCV 2 coverage** at the national and subnational levels.

**Research questions**

**Primary:**

i. What **% change in MCV1 and MCV2 coverage rate** is associated with switching to a 5-dose vial?

**Secondary:**

ii. What **% change in vaccination timeliness for MCV1 and MCV2** is associated with switching to a 5-dose vial?

iii. What **% change in the number of healthcare facilities offering MCV** during each immunization session and is the frequency of such sessions at the national and subnational level associated to switching to a 5-dose vial?

iv. What **% change in missed opportunities to vaccinate for MCV1 and MCV2** is associated with switching to a 5-dose vial?

v. What **% change in measles vaccine wastage** is associated with switching to a 5-dose vial?

vi. What **% change in proportions of zero-dose and under-immunized children** is associated with switching to a 5-dose vial?

vii. What **% change in coverage rates of routine childhood vaccines** is associated with switching to a 5-dose vial?

# Objective 2

To evaluate the **impact of the MCV 10-dose to 5-dose vial switch on HCW and caregiver perceptions and behavior**.

i. What is the **knowledge, attitudes, and practices among healthcare workers** before and after switching to 5-dose vials?

ii. What is the **knowledge, attitudes, and practices among the caregivers of children** vaccinated with MCV before and after switching to 5-dose vials?

# Objective 3

To obtain **real-world implementation data** on the **practicalities, cost assessments, equity analysis and cost-evaluations** pertinent to the **effectiveness of the MCV switch.**

**Research questions**

i. What are the **actual costs and timelines of implementing** the MCV 10-dose to 5-dose vial switch compared to the pre-switch estimates?

ii. Is the switch **cost-saving and cost effective**?

iii. What is the **economic implication of switching** from MCV 10-dose to 5-dose vial in different country contexts?

iv. What are the **equity implications** to be considered?

v. What are the **enablers and barriers** of the MCV 10-dose to 5-dose vial switch implementation process?

vi. What are the **tools and processes** used during MCV 10-dose to 5-dose vial switch implementation process?

vii. What are the **lessons learned** and **best practices** for the MCV 10-dose to 5-dose switch in different country contexts?

viii. How might **learnings** from the MCV 10-dose to 5-dose switch inform other similar presentation switches such as yellow fever vaccines (YFV).

# Objective 4

To document the **lessons learned** and identify the short-, mid- and possible long-term **benefits of leveraging local academia to support evidence compilation for NITAGs for decision-making**.

**Research questions**

i. What are the characteristics of **existing models** (examples, ways) of **linking local academia with NITAGs** for evidence gathering, impact evaluation and decision making for vaccine optimization and prioritization?

ii. What **adaptations** are necessary for the existing models to be piloted in MCV 10-dose to 5-dose switch study countries?

iii. What are the main **enabling factors and barriers** for this model of linking local academia and NITAGs in the study countries?

iv. What are the **key questions** that **NITAGs** in the study countries should consider to inform recommendations on the MCV10-dose to 5-dose vial switch (e.g. cost comparison, product comparison, others e.g., context-specific issues)?

v. What **kind of support** is **local academia** able to provide and not able to provide on the key questions?

vi. What are the short-, mid- and possible long-term direct and **benefits and impact** seen on the joint **academic-NITAG** collaboration on NITAG functioning and maturity level?

vii. What are the **lessons learned and best practices** for the adapted model in the study countries?

# Overview of study methodology

To address **objectives 1& 3**, an **integrated mixed methodology approach** was employed using items pooled from various tools loaded as questionnaires onto RedCap database on electronic tablets.

To address **objective 2**, **in-dept interviews** were conducted with healthcare workers and caregivers of age-appropriate children.

**Objective 4** is a 'light-touch' landscape analysis. It employed a **combination of literature review and primary study** which consisted of in-depth interviews with relevant key stakeholders (NITAG Chairs, secretariat, immunization support partners, and the academia)

# Examples of tools adapted for the study

Interview tool for the impact of Measles-Containing Vaccine (MCV) switch from 10 vials to 5 vials on caregivers of children age 12 to 36 months

## INTERVIEW TOOL FOR THE IMPACT OF MEASLES-CONTAINING VACCINE (MCV) SWITCH FROM 10 VIALS TO 5 VIALS ON CAREGIVERS OF CHILDREN AGE 12 TO 36 MONTHS

### INTRODUCTION

My name is *[NAME]*. The organisation I am working for, *[NAME OF ORGANISATION]*, is interested in the costs and expereience that caregivers face when they take their children for immunization, specifically MCV.

Permission has been received to access this health facility and to view your Vaccination history.

Partaking in the study involves an interview designed to allow us to collect details and data about medical and non-medical costs of MCV vaccination for your child(ren).. We will ask about any difficulties you have had in accessing Vavccination care. At some point I will ask you about your personal income and the income of your household. We will not provide this information to any tax or welfare authorities, even after the study has been completed.

Other than completing the interview you will not be asked to do anything different after today from what you would already do if you were not in the study. All the information you provide will be kept confidential and only used for research purposes.

There are no risks or direct benefits associated with partaking in the study.

Taking part in this study is voluntary. You can choose not to take part and if you join, you may quit at any time. If you decide not to participate, there will be no negative consequences.

Please take your time to read through this information sheet (*ENUMERATOR TO GIVE CAREGIVER THE INFORMATION SHEET AND CONSENT FORM)* and ask any questions that you may have. If you agree to participate, please sign the consent form and we can begin the interview.

s: On Accessibility: Investigate

### IMMUNIZATION SUPPLY CHAIN AND SERVICE DELIVERY

### BASELINE HEALTH FACILITY COSTING QUESTIONNAIRE[1]

*Note: This is costing questionnaire will need to be modified to align with the country context. Most of the information below can be obtained by interviewing the medical staff person in charge of the facility, with some data obtained from the accounting office (if applicable). In the human resource section, each staff person present should be interviewed separately. The questionnaire will be modified to be relevant to the activities at the district.*

#### I. FACILITY BASIC INFORMATION

| **INTERVIEW INFORMATION** | | | |
|---|---|---|---|
| ***Number*** | ***Question*** | ***Answer*** | ***Interviewer guide*** |
| | Health facility name | | |
| | District located in | | |
| | Title / designation of person being interviewed | | |
| | Name of interviewer | | |
| | Date of interview | | |
| **HEALTH FACILITY GENERAL INFORMATION** | | | |
| ***Number*** | ***Question*** | ***Answer*** | ***Interviewer guide*** |
| | What is the location of this health facility? | ☐ Urban<br>☐ Peri urban<br>☐ Rural | |
| | What is the main power source for lights for this facility? | ☐ Electricity | |



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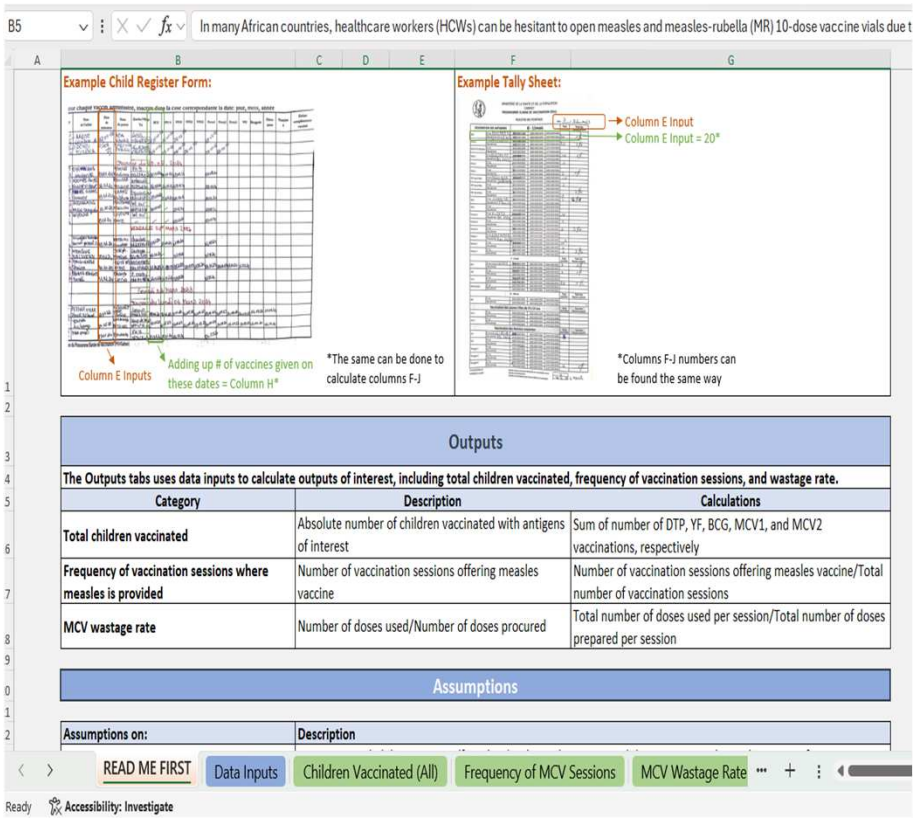
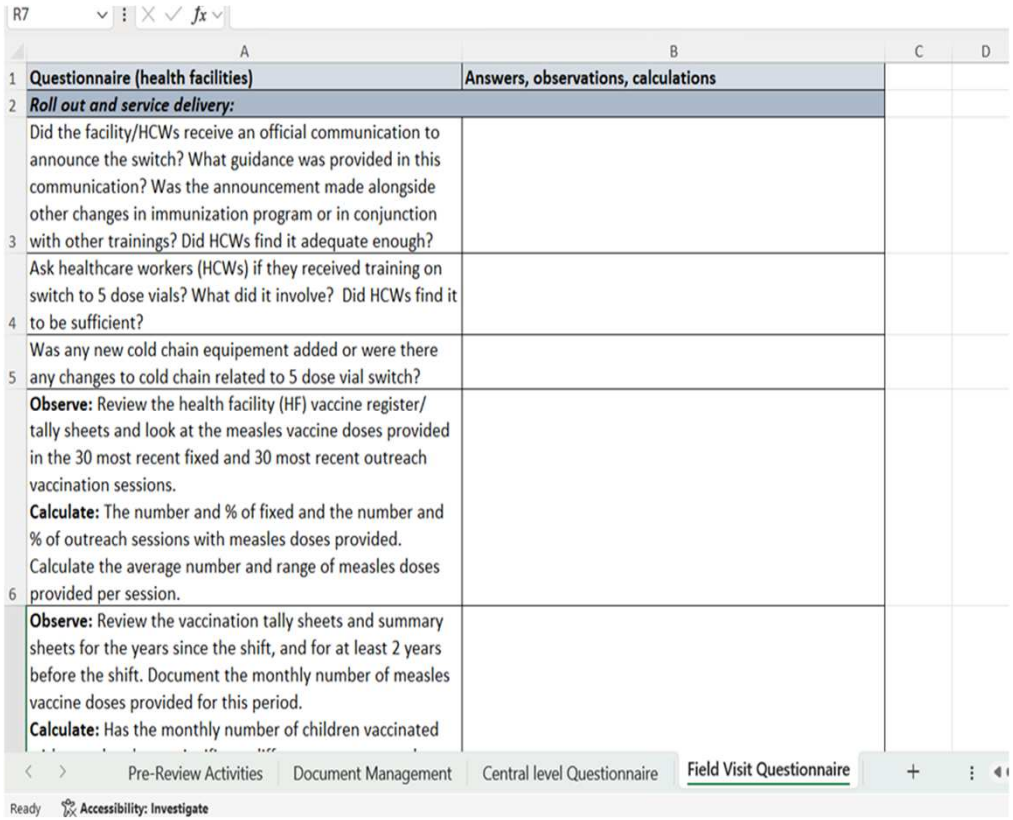
# Examples of tools adapted for the study




MCV 5 dose M&E tool




MCV 5 dose implementation review template



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# Screenshot of survey instrument– examples from Zambia

| Record ID | Caregiver Eligibility Screening & Informed Consent | Caregivers Of Children Age 9 To 24 Months |
|---|---|---|
| 1 Caregiver ID: 41043321 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 2 Caregiver ID: 41042322 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 3 Caregiver ID: 41042233 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 4 Caregiver ID: 41042184 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 5 Caregiver ID: 41042195 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 6 Caregiver ID: 41042196 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 7 Caregiver ID: 41042197 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 8 Caregiver ID: 41042278 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 9 Caregiver ID: 41042199 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 10 Caregiver ID: 410423310 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 11 Caregiver ID: 410423011 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 12 Caregiver ID: 410393512 \| Chikonshi Mini Hospital - (Mansa, Luapula Province) | ● | ● |
| 13 Caregiver ID: 410392113 \| Chikonshi Mini Hospital - (Mansa, Luapula Province) | ● | ● |
| 14 Caregiver ID: 410393214 \| Chikonshi Mini Hospital - (Mansa, Luapula Province) | ● | ● |
| 15 Caregiver ID: 410393215 \| Chikonshi Mini Hospital - (Mansa, Luapula Province) | ● | ● |
| 16 Caregiver ID: 410392316 \| Chikonshi Mini Hospital - (Mansa, Luapula Province) | ● | ● |
| 17 Caregiver ID: 410392717 \| Chikonshi Mini Hospital - (Mansa, Luapula Province) | ● | ● |
| 42 Caregiver ID: 410422442 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 43 Caregiver ID: 410422843 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 44 Caregiver ID: 410423344 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 45 Caregiver ID: 410422045 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 46 Caregiver ID: 410425246 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 47 Caregiver ID: 410423747 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 48 Caregiver ID: 410422848 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 49 Caregiver ID: 410422849 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 50 Caregiver ID: 410424350 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 51 Caregiver ID: 410423251 \| Mwana Chama - (Mansa, Luapula Province) | ● | ● |
| 72 Caregiver ID: 410434072 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 73 Caregiver ID: 410433273 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 74 Caregiver ID: 410431874 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 75 Caregiver ID: 410432375 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 76 Caregiver ID: 410432276 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 77 Caregiver ID: 410432777 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 78 Caregiver ID: 410432178 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 79 Caregiver ID: 410433279 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 80 Caregiver ID: 410433080 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |
| 81 Caregiver ID: 410433981 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | ● | ● |

Figure1: Screen shot of the list of records in the caregiver tool in the RedCap® instrument

# Some captured data – examples from Zambia

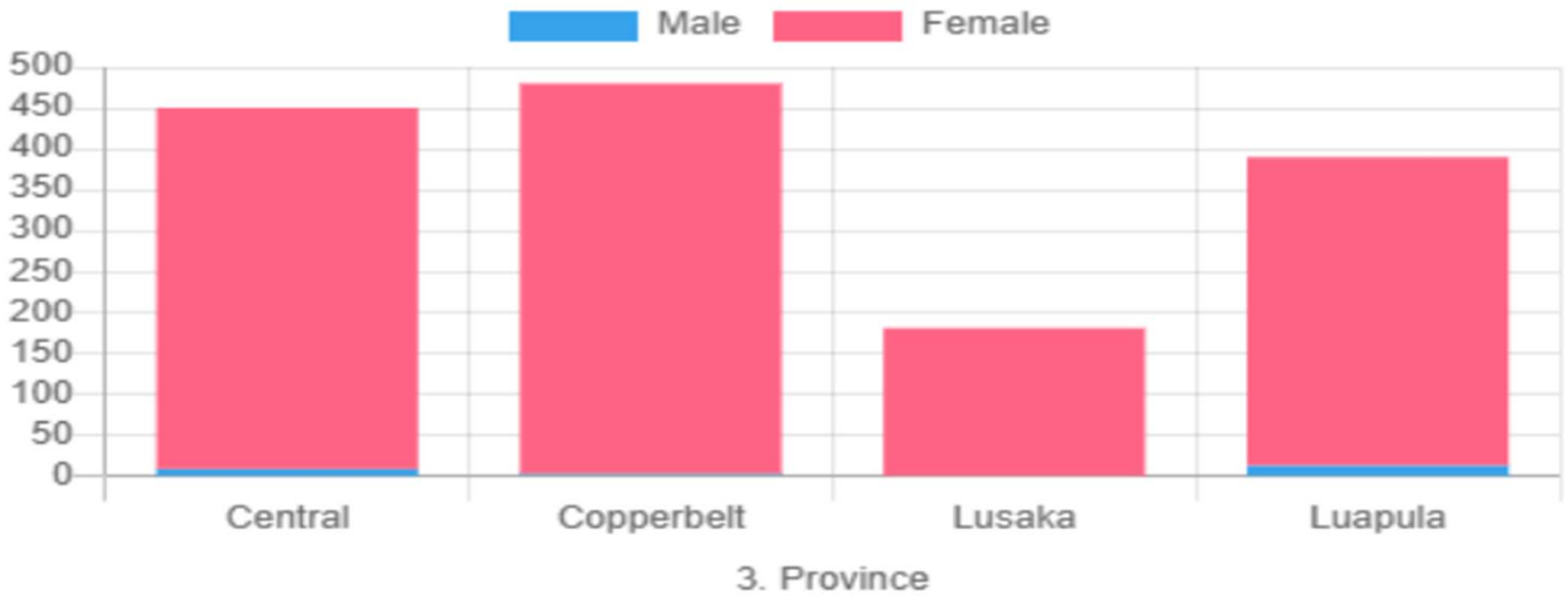


Figure2:Gender distribution of caregivers across the Central, Copperbelt, Lusaka and Luapula provinces

# Screenshot of survey instrument– examples from Zambia

| Record ID | Facility Basic Information | Cold Chain & Dry Goods | Cold Chain - Refrigerators | Cold Chain - Freezers | Cold Chain - Cold Boxes | Cold Chain - Vaccine Carriers | Transport - Distribution | Transport - Health Center Vehicles | Outreach Immunization - Locations | Per Diem Costs for Child Health Week | Outreach Immunization - Per Diem Costs | Waste Disposal & Stockouts of Vaccines and Syringes | Human Resources |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 Facility ID: 41042 \| Mwana Chama - (Mansa, Luapula Province) | | | | | | | | | | | | | |
| 2 Facility ID: 41039 \| Chikonshi Mini Hospital - (Mansa, Luapula Province) | | | | | | | | | | | | | |
| 5 Facility ID: 41043 \| Katangwe Rural Health Centre - (Mansa, Luapula Province) | | | | | | | | | | | | | |
| 7 Facility ID: 41038 \| Chisunka Rural Health Centre - (Mansa, Luapula Province) | | | | | | | | | | | | | |
| 8 Facility ID: 41040 \| Mikula Health Post - (Mansa, Luapula Province) | | | | | | | | | | | | | |
| 9 Facility ID: 41145 \| Mulwe Health Post - (Nchelenge, Luapula Province) | | | | | | | | | | | | | |
| 10 Facility ID: 41144 \| Kasumpa Health Post - (Nchelenge, Luapula Province) | | | | | | | | | | | | | |
| 11 Facility ID: 41249 \| Chinweshiba Health Post - (Samfya, Luapula Province) | | | | | | | | | | | | | |
| 12 Facility ID: 41041 \| Luamfumu Rural Health Centre - (Mansa, Luapula Province) | | | | | | | | | | | | | |
| 13 Facility ID: 41147 \| Ntoto Health Post - (Nchelenge, Luapula Province) | | | | | | | | | | | | | |
| 14 Facility ID: 41248 \| Chikunyu Health Post - (Samfya, Luapula Province) | | | | | | | | | | | | | |
| 19 Facility ID: 41250 \| Samfya Stage II Rural Health Centre - (Samfya, Luapula Province) | | | | | | | | | | | | | |
| 20 Facility ID: 2623 \| Ndeke Urban Health Centre - (Ndola, Copperbelt Province) | | | | | | | | | | | | | |
| 24 Facility ID: 2622 \| Hillcrest Urban Health Centre - (Ndola, Copperbelt Province) | | | | | | | | | | | | | |
| 25 Facility ID: 2628 \| Masala Main Urban Health Centre - (Ndola, Copperbelt Province) | | | | | | | | | | | | | |
| 29 Facility ID: 41146 \| Shimpundu Health Post - (Nchelenge, Luapula Province) | | | | | | | | | | | | | |
| 30 Facility ID: 2626 \| Kamensopanshi Health Post - (Ndola, Copperbelt Province) | | | | | | | | | | | | | |
| 31 Facility ID: 2629 \| Roma Health Post - (Ndola, Copperbelt Province) | | | | | | | | | | | | | |
| 32 Facility ID: 2627 \| Commando Urban Health Centre - (Ndola, Copperbelt Province) | | | | | | | | | | | | | |
| 33 Facility ID: 2520 \| Lulamba Health Post - (Kalulushi, Copperbelt Province) | | | | | | | | | | | | | |
| 34 Facility ID: 2624 \| 21 Miles Health Post - (Ndola, Copperbelt Province) | | | | | | | | | | | | | |
| 35 Facility ID: 2419 \| Luano Kapisha Mini Hospital - (Chingola, Copperbelt Province) | | | | | | | | | | | | | |
| 36 Facility ID: 2521 \| Nangongwe OPD/Maternity Health Centre - (Kalulushi, Copperbelt Province) | | | | | | | | | | | | | |
| 37 Facility ID: 2418 \| Muchinshi Rural Health Centre - (Chingola, Copperbelt Province) | | | | | | | | | | | | | |
| 38 Facility ID: 2417 \| Chingola Correctional Health Post - (Chingola, Copperbelt Province) | | | | | | | | | | | | | |
| 39 Facility ID: 2416 \| Ipafu Rural Health Centre - (Chingola, Copperbelt Province) | | | | | | | | | | | | | |
| 40 Facility ID: 2625 \| Tug-Argan Urban Health Centre - (Ndola, Copperbelt Province) | | | | | | | | | | | | | |
| 41 Facility ID: 2730 \| Lubengele Urban Health Centre - (Chililabombwe, Copperbelt Province) | | | | | | | | | | | | | |
| 42 Facility ID: 1312 \| Kalwelwe Health Centre - (Kabwe, Central Province) | | | | | | | | | | | | | |
| 43 Facility ID: 2751 \| Kawama Health Post - (Chililabombwe, Copperbelt Province) | | | | | | | | | | | | | |
| 44 Facility ID: 1313 \| Natuseko Urban Health Centre - (Kabwe, Central Province) | | | | | | | | | | | | | |
| 45 Facility ID: 1311 \| Bruneli Health Post - (Kabwe, Central Province) | | | | | | | | | | | | | |
| 46 Facility ID: 1315 \| Medium Prison Health Post - (Kabwe, Central Province) | | | | | | | | | | | | | |

Figure 3: Screen shot of costing data capture at facility level for cold chain equipment and related matters

# Some captured data – examples from Zambia

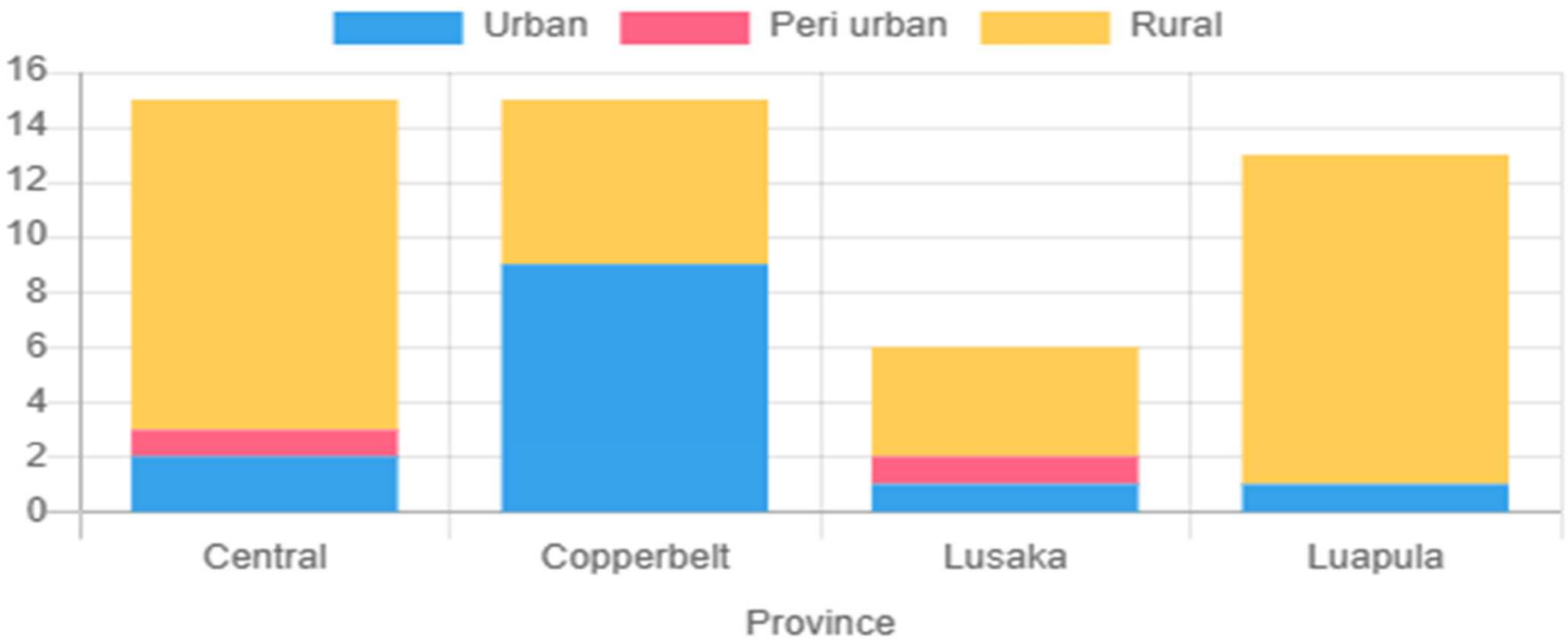


Figure 4 : Distribution of facility type; Urban, Peri Urban and Rural facilities across the Central, Copperbelt, Lusaka and Luapula provinces

# Screenshot of survey instrument– examples from Ethiopia

| Record ID | 1.1. Household identification & location /የቤተሰብ መለያ እና አካባቢ/ Meeshaa Odeeffannoo Walitti Qabuu/ AQOONSIGA & GOOBTA | 1.2. Sociodemographic Characteristics Of The Child And | 1.3. MCV1 Vaccine Coverage Household data before switch | 1.4. MCV2 Vaccine Coverage household data before switch | 1.5. Cost-effectiveness/costing assessment tool from care givers before the switch |
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# Screenshot of survey instrument– examples from Ethiopia

| Record ID | 2.1. Health Facility characteristics and Identification | 2.2. MCV Vaccine related facility data before switch | 3.1. General cost before switch | 3.2. Health Facility Cold chain and dry goods before switch | 3.3. Vaccine Supply Logistics before switch | 3.4. MCV vaccine distribution logistics before switch | 3.5. Costing of outreach MCV immunization activities before switch | 3.6 Costing of mobile MCV immunization activities before switch | 3.7. Waste disposal costing for MCV immunization before switch | 3.8. Human resource costing for MCV vaccination before switch |
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# Some captured data – examples from Ethiopia

**Administrative Coverage (Using HF report)**

| | MCV 1 | MCV2 |
|---|---|---|
| Target number of children for MCV vaccination for the study catchment in the 3 Months before switch | 11,180 | 10,948 |
| Number of Children vaccinated for MCV for the study catchment in the 3 Months before switch | 8428 | 7897 |
| Coverage | 75.4% | 72.1% |

**Household (survey) Coverage**

| | MCV 1 | MCV2 |
|---|---|---|
| Number of Children Eligible for MCV before switch in the 3 Months before switch | 1045 | 1135 |
| Number of children who received the va ccine in the 3 Months before switch | 775 | 775 |
| Coverage | 74.2% | 68.3% |

# Emerging qualitative insights – examples from Zambia

## Knowledge – Caregivers

- Although most caregivers could not identify the vaccine their child received as the measles containing vaccine, they could, however, articulate where on the body it was injected and when it was given.

- Due to the switch happening various times at facility level over the last 2 years, most caregivers had no conscious awareness of the switch, they did however notice that they were no longer asked to wait till a desired number of children were available for vaccination (usually 6-7) or turned away and told to come at a later date.

# Emerging qualitative insights – examples from Zambia

## Attitudes – Caregivers

No considerable change in attitudes were expressed by the caregivers, however, when it is hypothesized that the change might motivate those caregivers that were reluctant to take their children for vaccination because of the possibility of being turned away if the desired number of vaccinees is not attained, they opined that the change would have a positive effect on vaccination uptake.

# Emerging qualitative insights – examples from Zambia

## Knowledge - Healthcare Workers (HCWs)

- HCWs are aware of the switch, although not always certain exactly when it occurred at their respective facilities
- Efforts to communicate the switch to HCWs were done differentially across districts and facilities but were mostly poorly done – most HCWs just saw the 5-dose at their facility and had to figure out how to use it on their own.
- Some facility Heads were called by the district pharmacy to inform them of the change; they then passed on the information during weekly or monthly clinical meetings with no infographics
- Little to no time was given for the HCWs to process the change before they had to start using the 5-dose vials

# Emerging qualitative insights – examples from Zambia

## Attitudes - Healthcare Workers (HCWs)

- The switch was received with enthusiasm
- Before the switch, HCWs feared wasting doses, despite being told that wastage wasn't a priority
- HCWs don't think that there was a considerable change in preparation, reconstitution, or maintaining the cold chain with the change
- With regards to caregivers' awareness of the switch, most HCWs initially said 'no'. But after some reflection, or probing, most felt that it could be leverage to encourage caregivers to bring their children for vaccination

# Emerging qualitative insights – examples from Zambia

## Practices - Healthcare Workers

- Eagerly used the 5-dose
- Despite believing that it is important to share information with caregivers about the switch, in practice, most did not share the information

# Some insights from the landscape analysis

- There is no documented evidence of the process of a formalized linkage between a National Immunization Technical Advisory Group (NITAG) and an academic institution.
- Some matured NITAGs in high income countries have their secretariat housed in academic institutions.
- The current relationship between the NITAGs of the study countries can be described as informal or 'ad-hoc'.
- The need to have a formal relationship between NITAGs and academic institutions was identified as critical to the effective and efficient operations of NITAGs, and beneficial to the individual academics and the academic institutions at large.
- The suggested mode of formalization was contextual; however, the general concession was the need to engage **all relevant** stakeholders.

# Journey map- our novel value-add

# What is a journey map?

It is a research-based storytelling tool that communicates the journey from decision to service provision and acquisition.

A journey map can be described as a tool used to visualize and understand the steps and interactions involved in a particular process from the perspective of those involved, giving a clear understanding of their actions towards achieving their final goal. It allows for the translation of their insights into intelligible visual formats for decision making in various scenarios.

A journey map helps simplify complex experiences and create a shared understanding

It provides a 360-degree view of the people involved, the step-by-step actions, processes involved, channels and touchpoints involved in a journey

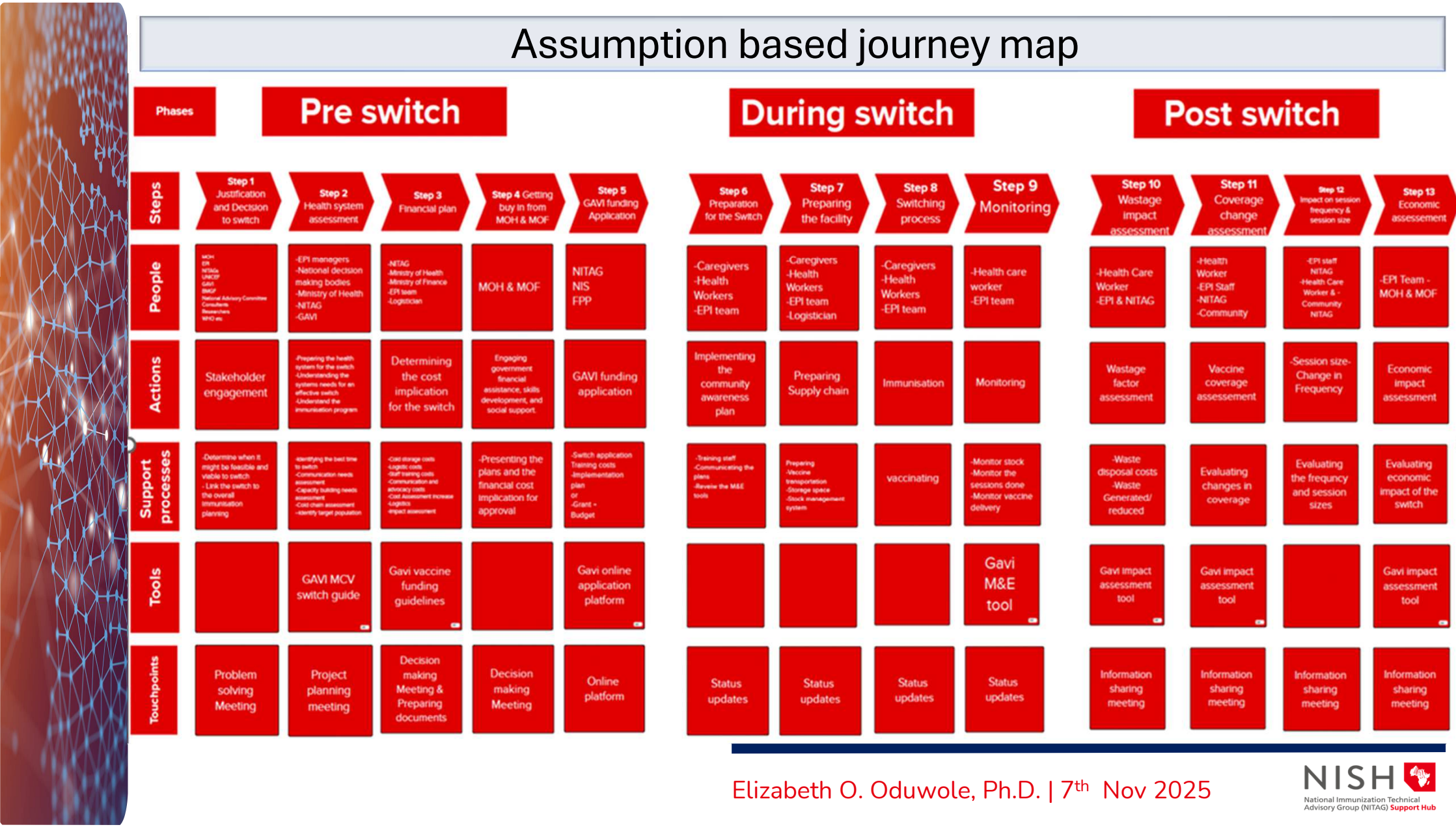
# What is the Journey map in the MCV switch study?

It is an end-to-end visualization of the entire switching journey of the 10-dose vials to 5-dose vials, from the decision-making process through to the implementation and impact assessment.

It will include the people involved in each phase of the switching journey, expectations, actions, processes and needs, in the execution of the switch.

The journey map will be used throughout the different phases of the MCV switch study to visually document the switch process allowing for the identification of the process gaps, breakdown of silos, depiction of complicated relationships, and visualization of key touchpoints at every stage of the MCV switch process, from diverse viewpoints.

# Assumption based journey map

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# MCV journey map template

| Phases | PRE SWITCH | | | | | DURING THE SWITCH | | | | POST SWITCH | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Steps | Decision to switch | Health System Assessment | Developing a financial plan | Getting buy in from MOF by MOH | GAVI Funding Application | Preparing people for the switch | Preparing the Health Facilities | Switch implementaton | Monitoring | Waste Impact assessment | Coverage Change assessement | Impact on frequency of sessions and the size | Economic Evaluation |
| People | | | | | | | | | | | | | |
| Main activities | | | | | | | | | | | | | |
| Tasks | | | | | | | | | | | | | |
| Tools &Technologies | | | | | | | | | | | | | |
| Touchpoints | | | | | | | | | | | | | |

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# Some anticipated use-case of the journey map in this study

To ensure that every actor within the health system is aligned to assist in making the journey happen

To understand what happens along the way, at all touchpoints and across health system

To help countries optimize their strategies and create a seamless switching processes/strategies.

# Emerging notables…

- The switch is highly recommended to countries considering it and those yet to do so.
- Emerging evidence indicates minimal impact of the switch on existing structures of health systems including cold chain capacity
- There is a need to formalize the relationship between NITAGs and academic institutions for optimal functioning of the formal, and impactful effect of the latter
- The journey map in progress will be of immense benefit to all countries.
- The study is still ongoing; the story is yet to be told…

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# Thank you for Your Attention

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Questions?

Thank you!