

Pasteur; in addition, she has received funding through her institution to conduct HPV vaccine studies for Merck Sharp and Dohme and GlaxoSmithKline. SMG is a member of the Merck Global Advisory Board and the Merck Scientific Advisory Committee for HPV. MYC has been an investigator on investigator initiated research grants from Merck Sharp and Dohme. MGL receives unrestricted grants from Boehringer Ingelheim, Gilead Sciences, Merck Sharp and Dohme, Bristol-Myers Squibb, Janssen-Cilag, ViiV HealthCare. All other authors have no conflicts of interest.

016.2 EVIDENCE, POLITICS AND CULTURES IN POLICYMAKING: POLICY ANALYSIS OF HPV VACCINE INTRODUCTION IN INDIA

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Introduction Despite India having the highest burden of cervical cancer globally, the HPV vaccine is not part of the routine immunisation programme. The decision process on HPV vaccine was put-off in 2010 shortly after a high profile vaccine demonstration trial was suspended when five girls died. Although the evidence that the deaths were linked to the vaccine is highly contested, nonetheless a political decision on HPV vaccine introduction differed. The purpose of the current study is to explore the political, socio-economic and cultural factors influencing the HPV policy decision in India. Evidence from the study may have implications for future vaccines targeting STIs in contested policy environments.

Methods We used qualitative methods for policy analysis based on primary data collection supplemented with in-depth documentary review. Semi-structured interviews were conducted with 46 participants including policy makers, health system actors and community based organisations at State and National level. We used the Gilson and Walt Health policy triangle framework to analyse the data.

Results Interim results have highlighted a number of features of the policy process in India, which may have influenced vaccine policy decision-making. These include: lack of adequate policy space for transparent discussion of concerns; strong suspicion of conflict of interest among researchers and international donors; mistrust of Government officials by civil society members; Government concerns around sustainable funding options; and a dearth of Government initiatives to promote culturally sensitive sexual health issues.

Conclusion The [non]-introduction of the HPV vaccine into the Indian policy landscape was influenced by a variety of factors including contested empirical evidence of safety and perceptions of institutional (particularly commercial) interests outweighing public health evidence. This study provides important lessons not only for the future introduction of HPV vaccine in India, but also for any other vaccines targeting STIs.

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016.3 HPV VACCINE INTRODUCTION IN THAILAND

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Introduction Cervical cancer is the second most common cancer in Thai women. Since HPV vaccination would be a complementary measure to the current cervical screening program, the Advisory Committee on Immunisation Practices in Thailand recommended HPV vaccination to school age girls. This study is the first report of school-based HPV vaccine introduction in Thailand which aimed to assess feasibility of including HPV vaccine into the national immunisation program.

Methods Two doses of bivalent HPV vaccine were given to 5th grade girls in Phra Nakhon Si Ayutthaya province at 0 and 6 months. To assess HPV vaccine acceptability, we interviewed public health staffs in 114 immunisation clinics, teachers in 93 primary schools and reviewed 1,736 parent consent forms. We surveyed 1,736 school girls to assess HPV vaccine coverage and established the Adverse Event Following Immunisation (AEFIs) Surveillance for HPV vaccine to monitor any AEFIs related to HPV vaccination. Cervical screening records were also explored to determine the effect of HPV program on the existing cervical screening program.

Results HPV vaccine acceptability among public health staffs, teachers and parents was 97.8%, 95.7% and 91.2%, respectively. The HPV vaccine coverage was 91.0% and 87.4% for the first and the second dose. There was no severe AEFIs reported, but most common AEFIs were "pain at injection site" (18.3%-22.0%), "fever" (2.1-2.6%), and "swelling and redness" (2.1%-2.5%). There was no evidence that declining number of cervical screening was due to HPV program and 91.7% of public health staffs thought HPV vaccination did not interfere cervical screening program performance.

Conclusion HPV vaccine introduction is well accepted and well integrated into the immunisation program. The vaccine is well tolerated and there is no evidence that the vaccination program had negative impact on the current cervical screening scheme.

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016.4 THE ESTIMATED IMPACT AND COST-EFFECTIVENESS OF NONAVALENT HPV VACCINATION IN THE UNITED STATES

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Introduction The objective of this study was to assess the health impact and cost-effectiveness of human papillomavirus (HPV) vaccination strategies in the United States. Specifically, we examined the incremental costs and benefits of the 9-valent HPV vaccine (9vHPV) compared to the quadrivalent HPV vaccine (4vHPV). Like 4vHPV, 9vHPV protects against HPV types 6, 11, 16, and 18. 9vHPV also protects against 5 additional HPV types 31, 33, 45, 52, and 58.